STATUS OF ALCOHOL AND DRUG EDUCATION IN OREGON SCHOOLS

by

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A DISSERTATION

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This study was conducted under the auspices of the Oregon Department of Education to assess the overall status of alcohol and drug education in Oregon schools. The degree of emphasis on traffic safety education in alcohol and drug curricula was also assessed. Funding for the study was provided by the Oregon Traffic Safety Commission (402 Traffic Safety program grant, #1183-10-308C-9).

The primary information base was data collected by an instrument consisting of 19 items which was sent to all 1,400 Oregon School principals. Usable data were

obtained from 583 (42%) of these principals. The information obtained by this process provided answers to the six research questions which dealt specifically with: a) the status of alcohol and drug education at each grade level; b) the extent of alcohol and drug education in relation to traffic safety; c) types of programs and instructional methods currently being used in schools; d) community attitudes towards supporting alcohol and drug education programs; e) community perception of the effectiveness of the existing alcohol and drug education programs; and f) the future trends of alcohol and drug education in Oregon schools.

To obtain additional data and further check the validity of the information provided by the school principals, a personal interview involving 128 students, 47 teachers and 44 parents was conducted in 16 randomly selected schools. The information obtained from these interviews provided additional insights into the actual status and community attitudes toward alcohol and drug education.

The overall results of the study indicated that: a) the time spent in all grades (K-12) for alcohol, drugs, and traffic safety education was minimal--an average of 2.5 hours (classroom time) per year for each of the three topics; b) school-developed curricula were the most

widely used instructional media for both alcohol and drug education; c) a combination of instructional methods was reported being used and the three most favored methods were films, lectures, and outside speakers; d) strong community support for alcohol and drug education programs was expressed by principals, teachers, parents and students; e) development and implementation of alcohol and drug education programs was favored by the majority of the principals.

VITA

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DEDICATION

This dissertation is dedicated to my family and my friend, Donald J. Porteous, who understood my dream and shared in my endeavor.

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INTRODUCTION

"The Real Truth"

They all live together
In a classy neighborhood
They have all kinds of talents
At which they are good

They have beauty, popularity
They're good at all sports
They do well in school
And seem never out of sorts

They get everything they want
Anything they ask for
Their families are kind and understanding
And advantages? Yes many, many more

It all happened that summer
Right after seventh grade
They mixed a fifth of Black Velvet
Into the lemonade

That was how it started
Now it's getting worse
If they don't let up soon
They'll end up in a hearse

Now they have wild parties
Drink stolen beers
They drive stolen cars
During their pre-high-school years

Their parents find out
But stop it they don't
They think it'll stop
But it won't; it won't

I look at them and sigh
All that potential wastes away
They ask me to join
But that game I just won't play

Now they're into drugs
Hash, speed, and pills
Bought from high-school thugs
To give them useless thrills

Their grades go down
Their pocketbooks dwindle
For a meager buck
They're willing to swindle

This is getting sick
Where will it end
And to think that these people
Are considered my friends

What can I do
To stop such a waste
I've got to do something
Something with haste

How can I watch
As they throw their lives away
They think being wasted
Just makes up an ordinary day

You think this is just a poem
About something that I have heard
This is not hype
Not merely written word

These kids are in your classes
Every period of every day
Those kids who are so promising
Are wasting their lives away

by Jodie Palmer

Jodie Palmer

Period 7 Careers
Kennedy Junior High School
Eugene, Oregon
April 30, 1983

Introduction

The exploding problem of drug abuse in the world is of paramount public concern. Drug experimentation and drug dependency have spread with frightening speed among all age, social and economic groups (15). Worldwide drug sales are an estimated $40 billion a year, and over one-quarter of these sales come from the United States. Within the United States, federal expenditures for drug abuse programs also "rose from $29 million in fiscal year 1967 to $129 million in 1970, $777 million in 1974 and roughly equivalent amounts in the following years" (90).

Over the past several years, drug abuse in the United States has evolved from an acute to a chronic problem.

> The heroin epidemic of the late 1960s has subsided, and the sudden explosion of increasing drug consumption continues to be high, crossing racial, cultural, social and economic lines, and involving millions of people using hundreds of substances" (78, p. 6).

The Strategy Council on Drug Abuse (1979) estimated that at least 280 million prescriptions for psychoactive drugs were written in 1977. The annual per capita intake of alcohol in 1976 was 2.65 gallons for every American 15 years of age or older.

In its Fourth Special Report to the U.S. Congress on Alcohol and Health, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimated that alcohol is a factor in ten percent of all deaths in the United States and that

about one in ten adult drinkers is likely to have a drinking problem or to become an alcoholic (55). Conservative estimates (NIAAA, 1983) indicate that alcohol-related problems in the United States in 1982 accounted for a direct and indirect expenditure of over $50 billion. These costs were attributable to lost production, motor vehicle accidents, health and medical costs, violent crimes, fire losses and social responses.

On the "illicit" end of the drug spectrum, there are an estimated 450,000 Americans who use heroin daily, nearly ten million Americans who have abused cocaine, and over 43 million who have used marijuana (78). According to Combs et al. (1982), there are 200,000 overdosed emergency room patients each year and that perhaps 12,000 or more die (13).

The current widespread drug abuse is not a problem that emerged yesterday. Drug abuse has been developing insidiously for many years. Levy (1969) notes that:

> We are a drug-using society. A large segment of our population looks to drugs to alleviate a host of physiological, psychological and social discomforts. Young and old alike are inundated with commercial sophisms eulogizing drug products. Within this persuasive cultural milieu, drug abuse is spawned. Education, to be effective, must first recognize the complex historical, social, and psychological setting as a powerful stimulus to the use and abuse of drugs (42, p. 3).

Today, despite billions of dollars that go into creating a plethora of regulations and drug regulatory agencies, America is as much a drug-oriented culture as

ever. Billions of dollars are spent each year to advertise a wide variety of mood-altering substances and to convince the buying public that chemical remedies are readily available for their physical and psychological problems (68). Drug and alcohol abuse is an extensive problem that all youths are exposed to even though some are not necessarily involved (15). The Department of Health, Education and Welfare, in their second Special Report to the Congress (64) states that

> the proportion of American youth who drink has been increasing so that currently it is almost universal. The highest scores on the index of possible problem-drinking behaviors were recorded in the youngest age group for which data were available, the 18-20 year olds (64, p. 72).

Although abuse of various drugs is widespread, alcohol is the most popular social drug used in the United States. According to some recent reports (100, 73), there may be as many as 450,000 teenage alcoholics in the U.S. and approximately 3.3 million "problem" drinking youth in the 14 to 17 age range. This amounts to 19 percent of the 17 million persons in this age group. National surveys conducted by the Research Triangle Institute under contract to the National Institute on Alcohol Abuse and Alcoholism's (NIAA's) Laboratory of Epidemiology and Population Studies (45) revealed the following:

* Most senior high school boys and girls have used alcohol by the time they reach 10th grade.

* The frequency of alcohol use increases significantly between the 10th and 12th grades.

* The sharpest increase in heavy drinking among senior high school boys occurs between the 10th and 11th grades.

* More senior high school boys than girls use alcohol, but the gap is narrowing.

* There is currently more alcohol use among suburban senior high school students than among those in big cities.

* Alcohol use among senior high school students nationwide has changed little in recent years, but has stabilized at a fairly high level since 1974 (45, p. 29).

The drug abuse phenomenon is spreading into geographical areas remote from the cities and crossing social, economic and sex barriers. One of the major concerns is the fact that drug abuse is currently reaching even younger children. Within this group the abuse varies from recreational use to addiction. Drug abuse has been correlated with lack of ambition, low self-esteem, poor academic performance, irresponsible behaviors, decreased coping abilities, rebelliousness, ego deficiencies and regressive tendencies (27, 32, 62).

In response to increasing drug abuse and corresponding negative social consequences, communities throughout the United States have instituted drug education programs. Alcohol and drug education has been part of public school programs for over 100 years and is now mandated by law in most states. Originally intended to teach abstinence, these

programs now focus on preventing the excessive and/or irresponsible use of alcohol and other drugs. There has also been a movement to stress other facets of human nature which include self-esteem, coping skills, and decision-making abilities which are believed to be correlated with the drug abuse phenomenon.

While the forms and goals of these preventive programs have been many and varied, little systematic evidence supporting their effectiveness exists.

In all 50 states the law requires that instruction about alcohol and drugs be given to every school-age child. However, the nature, content and depth of instruction is left up to each state, which in some cases delegates the responsibility to school districts. In Oregon, many school districts incorporate a preventive alcohol and drug component in their health education curricula. This effort can take many forms, ranging from casual coverage to full coverage that provides scope and sequence.

Statement of the Problem

There are 309 public school districts in the state of Oregon and because of their obligation to include alcohol and drug related instruction in their curricula, all would probably say that they have alcohol and/or drug education programs. There was a need to ascertain the grade level,

depth and content of the existing programs and determine whether or not there was a need to develop a statewide comprehensive program that can be implemented in all public schools. The purpose of this study, therefore, was to assess the present status of alcohol and drug education in Oregon schools. The extent of traffic safety education inclusion with alcohol and drug education was also determined. The data were collected through a 19-item questionnaire which was mailed to all the principals in Oregon schools.

Additional data were obtained by interviewing parents, teachers and students of 16 randomly selected schools.

Research Questions

In conducting this study, answers to the following research questions were sought:

1) What is the status of alcohol and drug education in Oregon?

2) What is the extent of alcohol and drug education in comparison to traffic safety?

3) What types of programs and instructional methods are being used?

4) What are community attitudes towards supporting alcohol and drug education programs?

5) How do communities perceive the effectiveness of alcohol and drug education programs?

6) What are the future trends of alcohol and drug education in Oregon?

Limitations and Delimitations

1. The findings of the study are limited to the 49 percent of the school principals who responded and the interviews (involving parents, teachers and students) conducted in 16 randomly selected schools.

2. In the United States all schools are required by mandate to include alcohol and drug instruction in school curricula. Therefore, some of the school principals may have inflated the ratings of their alcohol and drug education program.

3. The present attitudes of the respondents towards alcohol and drug education in schools may have affected the responses.

4. Questionnaires were employed in data collection for this study acknowledging all the inherent strengths and weaknesses associated with this technique.

5. The reliability of the obtained data dependent on the respondents' willingness to cooperate and give honest responses to the statements on the questionnaires.

Definition of Terms

Alcohol and drug education instructor -- An individual who is assigned to teach about alcohol and drugs in school.

Alcohol and drug education curricula -- Those materials and learning activities specifically designed to achieve

the educational goals of school districts in relation to alcohol and drugs.

Baseline data -- Descriptive data which establishes a basis or ground level from which relative amounts or degrees of change may be observed.

Commercial curricula -- Curricula material developed by outside sources and commercially available for use in local school districts.

DUII -- Is the common abbreviation for driving under the influence of intoxicants.

Significance of the Study

Preventing problem drinking, alcoholism and other drug-related problems has now become a national health goal (42).

> The single consistent fact made apparent through the numerous approaches to treating alcoholics -- hospitalization, drug therapy, psychotherapy, self-help, peer support programs -- is that recovery from drugs and alcoholism is so difficult that it would be better to prevent the illness than to have to cure it" (86, p. 21).

But as with other health-related problems that rely on lifestyle for prevention of illness, the state of the art in prevention of alcohol and drug abuse is in a rudimentary level and effective preventive programs are almost non-existent. Tarnai et al. (80) reported in 1981 that the recent reviews of educational efforts aimed at preventing alcoholism indicated that a variety of programs exist, but

rigorous research concerning the effectiveness of various models of alcohol education is virtually nonexistent.

> Relatively little is known about the effectiveness of these models in primary prevention, or about which components of alcohol education are most important for maximizing its effectiveness (80, p. 34).

When the drug problem stimulated public awareness during the late 1960s and early 1970s, much of the prevention efforts centered around alcohol and drug education in the schools. During this period, officials in Oregon and in other states generally believed that if factual information was provided to the youth, it would encourage them to make responsible decisions regarding the use, non-use, and abuse of alcohol and other drugs (91). As these types of educational approaches were evaluated within Oregon and across the United States, it became evident that "scare the hell out of them" tactics and/or alcohol and drug related fact sheets alone did not significantly dissuade alcohol or drug abuse. In fact, some reports indicate that in some cases, "it did the opposite by stimulating teenage curiosity and experimentation" (91, p. 2). The findings revealed that providing information to youth without helping them to sort and deal with the effective aspects tended to increase curiosity. Some educators feel that the increased curiosity increased tendencies to experiment (101).

In recent years, new preventive programs and approaches to prevention have been developing throughout the state.

These new approaches have been in the areas of parent effectiveness training, peer counseling, drop-in centers, training and consultation to school personnel, and public education. Many of Oregon's school districts have also incorporated a preventive component in their health education curricula. Some districts may not be conducting any coordinated educational efforts. Needless to say, the overall status of alcohol, drug, and traffic safety education in Oregon schools is not known. Whether the educational approaches are of a direct informational format or whether they utilize a "life skill" approach can only be determined by surveying the schools. Virtually all of the states require some instruction about alcohol in the public school curriculum by legal mandates.

In Oregon at the present time, voluntary organizations and government agencies like Oregon State University's Youth for Traffic Safety, the Mental Health Division, Oregon Center for Drug Information and the Oregon State Council on Alcoholism are currently providing resources (materials other than money) to local school districts. These groups are certainly making concerted efforts not only by providing students with materials and educational experiences, but also by creating public awareness. Their activities are commendable and no one can deny that they are essential and important in prevention of drug abuse. However, authorities

throughout the United States suggest that drug education is more likely to be effective if it is incorporated into a school's total education program as a regular part of the educational curriculum. Drug education curricula in schools allows for the opportunity to deal with feelings, misinformation, misconceptions, and attitudes. Furthermore, the school system has contact with age groups in which the majority of students are maturing and forming habitual behaviors. Given the necessary support to provide the ideal climate for learning, teachers have the daily opportunity to influence students and their attitudes concerning drug abuse. However, for drug education to be effective, it must be taught by teachers who have a thorough understanding of drugs, human motivations, and behaviors. This does not imply that the school is the only place where alcohol and drug education should take place. Communities and local school systems which have made the decision to provide alcohol and drug education have the responsibility to plan and carry out self-evaluation studies of the existing instructional programs to determine their existing strengths and weaknesses.

CHAPTER II

REVIEW OF RELATED LITERATURE

Extent of Teenage Drinking

The vast majority of teenagers in America have experimented with alcoholic beverages. A recent analysis of 120 surveys of American teenage drinking practices from 1941 to 1975 shows that more than 70 percent of today's teenagers have had a drink. According to Milgram (1982), the initial drinking experience usually takes place around 13 years of age and usually in the home with parents or other adult authority figures present (48). The number of teenagers who reported ever having been intoxicated has increased dramatically from 19 percent in 1966 to 45 percent by 1975. The proportion reported as being intoxicated at least once a month rose from 10 percent in 1966 to 19 percent by 1975 (46, 86). The United States Department of Justice statistics for 1976 "indicate that 9,679 youths under the age of 15 were arrested in liquor law violations and 271 of the children were 10 years of age or younger" (18, p. 6). The same source (18) reported that of the children who were 10 years of age or younger, 50 were charged with driving under the influence and 240 were charged with drunkenness. In a

1978 national survey of high school drinking practices, 34 percent of tenth through twelfth grade youth reported having been drunk four or more times during the previous year and 23 percent reported driving after having had "plenty to drink" (86). Negative consequences related to this type of drinking behavior included 16 percent of the students experiencing difficulties with friends, ten percent receiving criticism from dates, eight percent getting into trouble with police and four percent getting into trouble with school personnel (8). A study conducted in one of the West Coast schools indicated that "45 percent of fourth, fifth and sixth graders considered themselves to be alcohol users and eight percent of the younger ones said that they drank at least once a week" (18, p. 7). According to a 1978 national survey of adolescents conducted by the Research Triangle Institute for the National Institute on Alcohol Abuse and Alcoholism, 87 percent of senior high students reported they had tried drinking at least once (101, 102). Approximately 20 percent reported drinking at least once a week. Williams (101) reports that these figures have remained high and relatively constant over the past several years, making alcohol the drug most widely used by American youth. In 1982 the first lady of the United States, Nancy Reagan, reported to the American Medical Association her concerns about alcohol and youth. In her speech, she

indicated that alcohol and drug abuse is still high and that one out of every three youngsters between the ages of 12 and 17 is abusing liquor (17).

Overall, teenage drinking patterns and levels remained stable between 1974 and 1978 (101). However, a comparison of 1974 and 1978 findings on current use indicates that the gap between senior high school boys and girls is the product of minor decreases in drinking by boys as well as a rapid rate of increase in alcohol use by girls (72, 96). The San Mateo surveys and a 1974 national survey of high school students (97) indicate that the proportion of girls who drink alcohol has begun to approach that of boys, although the quantity consumed per occasion by girls is still smaller than that of boys. Although girls are not drinking as heavily as boys at each occasion, this phenomenon is gaining the attention of many parents and educators (4, 16).

While there is a need for educators and researchers not to exaggerate or over-dramatize the problem of youthful drinking, studies indicate that an unknown but significant number of young people experience mild to severe alcohol and drug-related problems. Perhaps a particular cause for concern about youngsters who drink excessively and frequently is the possibility that they will become alcoholic (25, 14, 20).

It is estimated that there are approximately 17 million young people in the 14 to 17 age bracket in the United States. Approximately 19 percent or 3.3 million of them are problem drinkers (58, 23). It should not be surprising, therefore, that we should have a special concern for young people. In summarizing his concern for young people and the recent increase in drug abuse, Smart (78) poignantly commented that:

> We have a special concern for young people because they represent extensions of ourselves. They come fresh and with little experience to the unsolved problems of the last generation. Since they are both the carriers of biological and cultural life, it is essential that we take a special interest in their problems and general behavior. In a real way they represent whatever hope exists for the future of our individual countries and for mankind in general (73, pp. 1, 2).

We must realize that today's young people are raised in drinking societies where per capita consumption of alcohol and other drugs are constantly increasing. Without proper methods of helping the youth to deal with these problems, further increases are expected to create even more problems for future generations. According to Smart (73), a low tolerance for alcohol among young persons probably leads to greater impairment than among adults whose drinking patterns started at a later time in life. Smart (73) believes that "this phenomenon would likely create problems in driving and the operation of all types of machinery for young drinkers" (73, p. 13).

Drinking, Driving and Traffic Fatalities

Public distress caused by thousands of deaths and hundreds of thousands of disabling injuries caused yearly by drunk drivers has been a major reason for the current concern about alcohol abuse (59). Approximately 46,000 Americans were killed by highway accidents alone in 1982 (86). Today, there are more than 100 million vehicles on the nation's roads. The American Automobile Association reports that more than 50,000 persons die each year in automobile accidents and that alcohol will be a major factor in at least half of these deaths. Drunk drivers kill 75 people every day and one every 20 minutes. One-third of all traffic injuries are also related to alcohol (86). These figures say nothing about the immense costs in wage losses, medical expenses, property damage and insurance costs. The American Automobile Association estimated in 1975 that of the more than 100 million American drivers, at least two-thirds drank alcoholic beverages at one time or another before driving (27). These figures do not necessarily reflect those of a New Year's Eve. In fact, on any normal Friday or Saturday night,

> if you were able to stop all the cars in America and check the drivers, you would find that one in ten was legally drunk. Moreover, only one in every 2,000 drunk drivers is arrested (43, p. 48).

Furthermore, the National Highway Traffic Safety Administration (NHTSA) indicates that the blood alcohol concentration on the average arrested drunk driver is around 0.20 -- twice the legal limit of 0.10 in most states (56). This blood concentration is especially hazardous since at 0.10, the legal limit in most states, the accident probability is 25 times greater than that of a sober person (43).

The Oregon Department of Transportation reported that there were 518 people killed in Oregon during 1982. Ninety of them showed blood alcohol concentration readings of 0.20 -- at least twice the rate for legal intoxication in Oregon. Motor vehicle crashes related to alcohol cost American society $1.8 billion a year (56). Traffic crashes cost Oregonians $350 million every year. Half of this cost is due to alcohol consumption. Approximately 8,000 or more pedestrians are killed and another 100,000 are injured in traffic accidents each year. What is even more surprising is that post mortem blood alcohol tests results indicate that "44 percent of those tested had been drinking and 35 percent had a blood alcohol concentration of 0.10 percent or greater" (56, p. 3).

The National Highway Traffic Safety Administration (1982) reports that up to ten percent of all drivers on weekend nights are legally drunk (57). There is also a potential problem of using alcohol in conjunction with other

drugs, particularly those having similar pharmacological actions such as sedation and tranquilization. Some chemicals, when combined with alcohol, produce a synergistic action whereby the total effect is greater and perhaps far greater than the sum of all drugs involved acting independently (79).

Besides motor vehicle accidents, alcohol has also been strongly implicated in deaths and injuries resulting from home, recreational and industrial accidents. Estimates of industrial casualties for 1975 were 12,600 deaths and 2,200,000 injuries according to the National Safety Council (101). Foreign studies have determined that alcohol was present in up to 40 percent of the fatal industrial accidents and up to 47 percent of other non-fatal industrial accidents (86).

Alcohol has also been implicated in up to 44 percent of civilian aviation accidents in which the pilot died. Although it is not yet known to what extent and in what manner alcohol might have caused these accidents, "researchers suggest that drinking may encourage risk-taking behavior and alter psychomotor performance" (86, p. 17).

The private act of drinking, when carried to excess, has consequences which affect society as a whole. Problem drinking and alcoholism cost the nation $46 billion in 1979; a cost that is still rising (58, 87, 88).

Teenage Drunk Driving and Traffic Fatalities

Although drunk driving is a problem that pervades all age groups of our population, of particular interest are recent investigations of drinking practices among teenagers. Motor vehicle accidents are the leading cause of death among young people 15 to 24 years of age (58, 3, 26). Among sober drivers, teenagers are two-to-three times more likely to be involved in accidents than drivers in their forties or fifties (101). Even low amounts of alcohol accentuate this difference and the trend becomes more pronounced as blood alcohol concentration increases (56). In addition to this, "the combination of learning how to drive and youthful risk-taking behavior are major factors accounting for the number one killer of teenagers in this nation" (92). In 1978, passenger vehicle drivers in the age group 16 and 17 years were involved in crashes that resulted in 4,198 deaths. Motor vehicles account for approximately half of all deaths of 16 to 19 year olds in the United States (37). According to Karpf and Williams (1983), teenage drivers contribute substantially to motor vehicle related deaths, both their own and others. Teenage drivers, according to Karpf and Williams, "have greatly elevated rates of fatal crashes involved per capita and especially per licensed driver" (37, p. 55). Perhaps the greatest concern is the fact that a

great deal of teenage drinking among moderate to heavy drinkers takes place in or around cars (101).

The major health problem for teenagers in the United States is injuries associated with drinking and motor vehicle use. In 1978, drivers under the age of 20 were involved in 11,500 crashes where there was at least one fatality. In addition, 5.6 million reported traffic accidents were caused by young drivers aged 15 to 20 (101). More deaths per licensed drivers are associated with the passenger vehicle crashes of 18-year olds than for any other single age (37). When the legal drinking age was lowered in several states, the rate of teenage involvement in car accidents increased sharply (43). Some states are now raising the drinking age again in an attempt to cut down on the numbers of crashes caused by young drunk drivers. Some experts feel that this move will have no effect since young people can acquire alcoholic beverages at will, thus, the legal change would simply legitimize existing behaviors. Other groups, like the civil liberties advocates, argue that if young people are old enough to serve in the armed forces as they did in Vietnam, then they should be old enough to purchase alcoholic beverages and liquor. Douglass (19) reported that the opposition to lowering the legal drinking age was also vocal, but not nearly as broadly based as the proponents.

> Religious organizations, residuals of the temperance movement, and similar groups argue that if 18 to 20-year olds were given the right to purchase and consume alcoholic beverages, then the alcohol related traffic accidents, public drunkenness and early alcoholism would increase (19, p. 18).

Many young people, however, argue that issues of drunk driving and minimum drinking ages should be kept separate. It may not be possible that the issues of drunk driving and minimum drinking ages can be kept separate especially at the time when traffic experts point out that "where drinking ages are increased, traffic deaths seem to decrease" (61, p. 8). The U.S. Department of Transportation and the National Highway Traffic Safety Administration cites the following facts which seems to summarize the extent of teenage drunk driving problems:

* Almost 60 percent of fatally injured teenage drivers were found to have alcohol in their blood systems prior to their crash, with 43 percent at legally intoxicating levels (i.e., greater than or equal to .10 percent blood alcohol concentration).

* Of the 25,000 persons who die each year in drunk driver accidents, 5,000 of those victims are teenagers. That means that 14 teenagers die <u>each day</u> in drunk driver accidents.

* Alcohol involvement in teenage fatal accidents is at least three times greater in nighttime accidents (between 8 p.m. and 4 a.m.) than it is in daytime accidents (between 4 a.m. and 8 p.m.).

* In addition, teenage drivers are involved in 1 out of every 4 injury accidents, with a total of 650,000 injured teenagers in 1980. Alcohol is involved in close to 20 percent of injury producing accidents, which means that 130,000 teenagers are injured per year in drunk driver accidents. So, <u>14</u> teenagers

die and an additional 360 teenagers are injured in alcohol related crashes per day.

* Although teenagers comprise only 8 percent of the driver population and account for only 6 percent of the vehicle miles travelled in this country, they add up to 17 percent of all accident involved drivers and at least 15 percent of all drunk drivers in accidents.

* Think of this: of 330 children born today in the U.S. (about the size of a small grade school), one will die and four will sustain serious or crippling injuries in an alcohol related crash before they reach the age of 24.

* The Surgeon General has reported that life expectancy has improved in the U.S. over the past 75 years for every age group except one. The exception is the 15 to 24 year old American whose death rate is higher today than it was 20 years ago. And the leading single cause of death for this age group is drunk driving.

* As if the pain and suffering were not enough, insurance companies have estimated that teenage drunk driver accidents are costing society close to $6 billion per year in damage, hospital costs, lost work.

It is estimated that there are 3.3 million teenage problem drinkers aged 14 to 17 in the United States. The number of girls with drinking problems is slowly catching up with that of boys (86). The growth in teenage drinking is cause for serious concern. Approximately 7.38 percent of all Oregon licensed drivers are in the 15 to 19 year age group. In 1982, drivers in this age group accounted for 14.7 percent of all accidents of which 12 percent were fatalities.

Public Reaction to Drunk Driving and Related Fatalities

With the realization that over half of the fatal car accidents in this country involve alcohol, wary citizens throughout this nation are waging war on drunken drivers. Many are relatives or friends of victims of traffic crises caused by intoxicated drivers (76). Others are mobilized by the realization that the consequences of drunk driving are pervasive and affects every member of every community.

Organizations such as Mothers Against Drunk Drivers (MADD), Students Against Driving Drunk (SADD), and Remove Intoxicated Drivers (RID) are creating public awareness in most states. Their activities include counseling victims and survivors of alcohol-related accidents, monitoring of the judicial and legislative systems, and organizing intensive lobbying for legislative reforms. Landamood (1982) reported that:

> MADD has mushroomed to 59 chapters in 29 states and has been hailed as a significant contributor to the passage of the new drunk-driving laws in California, Maryland, New York, Washington and Alaska. . . . The new law has made drunk-driving prosecutions easier, plea bargaining more difficult, and harsh punishment mandatory. In the last quarter of this year California saw a fourteen percent drop in overall traffic fatalities, a fifteen percent drop in drunk-driving arrests, and a fourteen percent drop in alcohol-related collisions (p. 68).

While legislation varies from state to state, reports indicate that as of August 1983, 45 states consider a person to be legally intoxicated if his/her blood contains .10

percent alcohol. This is roughly an equivalence of three beers, or three glasses of wine, or two shots of whiskey, gin or rum ingested by a 160 pound person within an hour (61). Five states that set their legal limits above .10 percent are Colorado, Georgia, Iowa, Maryland and Missouri (.15, .12, .13, .13, and .13 respectively). Oregon and Utah are the only two states in which the legal limit of blood alcohol concentration has dropped from .10 percent to .08 percent. Drinking age, legal Blood Alcohol Concentration (BAC), and first offense license suspension in different states are as follows:

State	Drinking Age	BAC	1st Offense License Suspension
Hawaii	18	.10	90 days
Louisiana	18	.10	60 days
Vermont	18	.10	1 year
Wisconsin	18	.10	3 months
Alabama	19	.10	90 days
Arizona	19	.10	30 days
Florida	19	.10	6 months
Georgia	19	.12	1 year
Idaho	19	.10	180 days
Iowa	19	.13	120 days
Minnesota	19	.10	30 days
Montana	19	.10	6 months
New York	19	.10	6 months
Tennessee	19	.10	1 year
Texas	19	.10	1 year maximum
West Virginia	19	.10	6 months
Wyoming	19	.10	90 days
Connecticut	20	.10	6 months
Maine	20	.10	45-90 days
Massachusetts	20	.10	30 days-1 year
Nebraska	20	.10	6 months
New Hampshire	20	.10	90 days
Rhode Island	20	.10	3-6 months

State	Drinking Age	BAC	1st Offense License Suspension
Alaska	21	.10	90 days
Arkansas	21	.10	90 days-1 year
California	21	.10	none
Colorado	21; 18, 3.2 beer	.15	1 year
Delaware	21	.10	3 months
District of Columbia	21; 18, beer & wine	.10	6 months
Illinois	21	.10	1 year maximum
Indiana	21	.10	60 days-1 year
Kansas	21; 18, 3.2 beer	.10	limited use
Kentucky	21	.10	none
Maryland	21	.13	60 days maximum
Michigan	21	.10	6 months-1 year
Mississippi	21; 18, 3.2 beer	.10	90 days-1 year
Missouri	21	.13	90 days
Nevada	21	.10	90 days
New Jersey	21	.10	6 months
New Mexico	21	.10	none
North Carolina	21; 19, beer & wine	.10	1 year
North Dakota	21	.10	91 days
Ohio	21; 19, beer	.10	60 days
Oklahoma	21	.10	1 year
Oregon	21	.08	1 year
Pennsylvania	21	.10	1 year
South Carolina	21; 18, beer & wine	.10	6 months
South Dakota	21; 18, 3.2 beer	.10	30 days
Utah	21	.08	90 days
Virginia	21; 19, beer	.10	6 months
Washington	21	.10	90 days

In 1971, Oregon became the first state to make driving with a blood alcohol content of .10 percent or more a crime. O'Gorman (1982) reported that Oregon may be the leading state that has backed a publicity and citizen-action program

to turn in drunk drivers. Newsweek (September 13, 1982) indicated that:

> Oregon has had the most experience -- its crackdown began in 1971, and the most success. During the 1970s, highway fatalities dropped 6 percent and Oregon's fatality rate declined 35 percent despite the presence of 46 percent more drivers and 62 percent more vehicles on the roads. Success may be due to more than tough laws. Oregon has coupled its legal effort with a media campaign that urges Oregonians to report drunk drivers to a special telephone hot line (p. 34).

New tougher laws are expected to go into effect in Oregon. A report released by the Oregon Department of Transportation, Motor Vehicle Division, on October 6, 1983 stated the new changes as follows:

> The level at which a driver is considered "under the influence of alcohol" drops from .10 percent to .08 percent. In other words, it will take fewer drinks for most drivers to get to the "unsafe" level for driving.
>
> Another change allows a chemical test to be taken without a person's consent if a police officer has probable cause to believe the person was driving under the influence and that tests will reveal that fault. This law applies when the person is unconscious or otherwise in a condition that makes him or her incapable of expressing consent to the tests or test requested.
>
> Police also may obtain a test of the blood to determine alcohol content, or a test of blood or urine, or both, to determine if drugs are present if a person expressly consents to the test or tests.
>
> Most drivers, however, will continue to run afoul of the implied consent law. It applies only to breath tests to determine if or how much a driver has been drinking. Drivers who refuse a breath test in certain off-highway locations, such as shopping center parking lots, will face a 120-day license suspension under the new law. In the past, the law applied only to public highways.

> Still another change tightens provisions on who may avoid a DUII (driving under the influence of intoxicants) conviction on the record by agreeing with a court to divert to an alcohol education or treatment program. It is aimed at closing what some officials have considered loopholes in the 1981 law.
>
> One new law is aimed squarely at trying to convince young people to stay away from alcohol and drugs. It allows a court to order the Motor Vehicles Division to deny driving privileges for periods of time ranging from 90 days up to several years.
>
> This happens if anyone between the ages of 13 and 17 is convicted or determined by a court to commit any crime, violation or infraction involving possession, use or abuse of alcohol or controlled substances. Driving a motor vehicle may not even be involved in the offense.

According to the proponents of the measure who spoke in the legislative hearings, these new changes will help deter young people. This rationale was based on the importance most young people place on getting their first driver's license.

National data on alcohol use, health, and motor vehicle accidents show that alcohol consumption, driving under the influence of alcohol, and involvement in alcohol-related accidents are extensive among youth, many of whom are under the legal drinking age.

Bell (1980) has stated that the problem confronting adults now is no longer one of having adolescents admit to their intensive drug use, but what is the prevention and cure of such addiction? Bell doubts if any of the programs designed for prevention and cure have met with consistent success. Frustrated parents throughout the United States in

an attempt to stop drug abuse by young abusers have formed peer support groups of their own. There are now more than 3,000 parent groups across the nation devoted to stopping alcohol and drug abuse within their communities. Despite the early efforts of these parent self-help groups which focused almost exclusively on banning the sales of drug paraphernalia, the objectives of many of these groups have now broadened to include a wide range of activities designed to prevent alcohol and drug abuse by young people.

While there have been no empirical studies on the impact of the parent action movement in different communities, Vejnoska (1982) indicated that subjective reports point to the following changes:

* Heightened community awareness and understanding of the substance abuse problem.
* Improved parental understanding of substance abuse and the parental opportunities for interaction.
* Greater cooperation among service agencies.
* Stimulation of improved services and the creation of a climate in which positive programming was possible.
* Getting schools, agencies and organizations, and parents to adopt a nonblaming approach to abuse prevention and intervention that has improved the climate for prevention programming.
* Changes in the ways in which children now view substances.
* Providing the momentum for changes in school policy regarding drugs in schools; groups have reportedly been instrumental in getting schools to enforce stricter discipline codes and in getting them to act

more directly and cooperatively with parents on the issue.

* Enhanced parental capability to cope with the problem and provide assistance to their children, even in families where substance abuse by youth continues (93, p. 15).

Organizations such as Mothers Against Drunk Driving (MADD), Students Against Drunk Driving (SADD), Remove Intoxicated Drivers (RID), and those made up by parent self-help groups are increasing public awareness of the drug abuse problem and creating a more positive climate for prevention programs.

Drug Abuse Prevention Efforts and the Role of the School

In the United States, the prevention of almost all undesirable conditions has historically centered around the educational enterprise (20, 22). Since the time of the Women's Christian Temperance Union (WCTU) Movement (1880-1910), the school has been called on time and time again to expend various efforts in an attempt to reduce alcohol and drug related problems (73, 22, 49). As a cornerstone institution of society, communities felt that the school "had a duty to help young people from coming under the evil influence of smoking, drinking, and narcotics use" (32, p. 415). The WCTU was a powerful force and was instrumental in the passage of laws which mandated instruction about the nature

and effects of alcoholic beverages and other drugs. Finn (24, 25) describes the action of the WCTU as follows:

> The Temperance Movement of the 1800s expanded on the goals of absention to include alcohol use and attempted to impose this standard as a new national norm. The Temperance Movement started with informal grassroots meetings of private citizens and expanded into formally constituted community organizations that attempted first, to close down retail alcohol outlets and eventually to institute legislation against all alcohol use, manufacture and sale (25, p. 6).

Whatever the merits and shortcomings of the type of instruction advocated by the Temperance proponents, no one can question their effectiveness as a pressure group in getting school laws, codes and regulations changed to include instruction about their topics of concern in public schools. Currently, virtually all the states require by law some instruction about alcohol in the public school curriculum (32, 53, 25). Nevertheless, according to Estes and Heinemann (22), sharp emotional disagreements concerning overall goals and plans of action have resulted in an "omission of instructional programs," or, at best, a shallow and inane coverage (22, p. 210). As a result, the field of alcohol education is presently in a rudimentary state with no clear-cut philosophy and guidelines (28, 22). Estes and Heinemann (22) summarized this disorganized drug education approach as follows:

> The only statement that can be made with a degree of certainty is that alcohol education within the school systems of the United States has a variety of names, which implies that it is handled in a variety of ways.

> In some school systems it may be called "value training education," in others, "alcohol abuse education" or even "temperance education." It may be handled as a separate course or as an integrated part of the curriculum. Time allotments may range from a one hour assembly program to a two week unit (22, p. 210).

It is obvious from the above observation that an infinite number of educational strategies and techniques can be subcategorized under the label of "drug education." The current flood of magazine articles, newspaper releases and television reports related to the use and misuse of drugs have also led to confusion and misunderstanding among educators, counselors, other health personnel in schools and parents. Although some of this material is excellent, reliable, and valid, some of it only glamorizes and attracts with obvious disregard for scientific accuracy (9, 32). Mileff may be correct when he states that "in the rush to teach about drug abuse," we resemble Stephen Leacock's mythical character who "flung himself from the room, flung himself on his horse, and rode off in all directions" (32, p. 424). Globetti (29) suggests that lack of consensus on the aims of alcohol education, along with methodological problems, is one of the major reasons for the failure to develop an effective nationwide drug education program. An effective alcohol education program will only be developed after testing a variety of different approaches (47). In fact, some states for the past few years have been in the forefront of the development and testing of innovative

curriculum approaches. These states draw on the federally funded models in some cases and develop their own approaches in others (101).

Chunko (10) reports that in some states the drug education programs within the health curricula are being upgraded in response to an increase in drug abuse among students in various grade levels. According to Bedworth (4), New York State took a leadership role in dealing with drug abuse when the legislature enacted the Critical Health Problems Legislation Education Law in 1967. This law became effective in 1967 and made provision for the development of a five-year program designed to deal with drug abuse. It was amended in 1969 and 1970 and is now a continuing law which calls for a mandatory program in health education in all schools in the State of New York. The primary emphasis is placed on the critical health problem areas of drug abuse, effects of excessive use of alcohol and the health hazards resulting from the use of tobacco. Bedworth (4, p. 23) states that:

> This law has become the mortar for laying the cornerstones for more effective health and drug education programs. Generally these cornerstones are essentially:
>
> * health education courses required for all students,
>
> * health classes taught by trained and certificated health educators,

* health education that is broad in scope, sequential, and related to the needs and developmental levels of students, and finally

* programs designed for community action and involvement in the health affairs of today.

The commissioner of education was directed to establish a continuing program for critical health problems designed not only with special emphasis placed on school-age children, but to educate citizens of New York State as well.

According to a study conducted by the American School Health Association under the auspices of Castile and Jerrick, 16 states have mandated comprehensive health education programs. In addition, 35 states have mandated education in alcohol, drugs, and tobacco. In most states, including Oregon, the choice of topics to be taught in health curriculum and other fields is left up to the individual school system or individual teacher. Globetti (28) has reported that this approach has created a hit-and-miss process to the "comprehensiveness" of education. Although alcohol and drug education in most school districts is considered as part of the health curriculum, it is often not covered, or at best may be discussed only in passing in health classes. The lack of status in which alcohol and drug education hold in a total school curriculum places these topics on a low priority list which perpetuates neglect in terms of their coverage. For example, in Oregon the ORS 336.067 requires public schools to:

> give special emphasis to instruction in honesty, morality, courtesy, obedience to law; respect for all humans, humane treatment of animals, effect of tobacco, alcohol, and narcotics upon the human system, and other specified moral and ethical lessons.

The law also requires the Superintendent of Public Instruction to prepare an outline with suggestions and to incorporate it in the courses of study for all public schools. But since most of the responsibility is left up to each school, the teachers are faced with ambivalence about content, depth, and type of instruction especially in the areas of alcohol and drugs which are considered very controversial. The teacher, as described by Sheppard (70), is the most strategically placed individual in controversial subject areas. With little or no objective background information, the teacher is often forced to "consider alcohol and drug-related issues from personal biases or ignorance or both" (71, p. 17). In some schools where health instructors may feel uncomfortable dealing with these topics, the instruction may follow a general pattern in which a speaker from a local law enforcement agency, local health department, hospital, drug rehabilitation center, or other local agency is brought in to lecture students on the implications of drug abuse. From this kind of approach, it is difficult to determine the amount of education that is taking place. The review of literature revealed that most

schools include at least 11 topics in their health curricula, viz:

1. Personal health
2. Mental and emotional health
3. Prevention and control of communicable diseases
4. Nutrition
5. Substance use and abuse
6. Accident prevention
7. Community health
8. Sex education
9. Consumer health
10. Environmental health
11. Family health

Since the choice of topics to be taught is left up to each schcol, the amount of coverage allocated to each of the above subject areas is difficult to determine. However, examination of a number of health textbooks revealed that alcohol and drug education would be allocated about nine to ten percent of the total curriculum class time -- that is, if all the above subject areas were covered according to presentation in the textbook.

One of the major concerns in combating the alcohol and drug abuse problem is the quality of training the teachers receive in this field. For an alcohol and drug education program to be effective in the classrooms, teachers must

have a basic knowledge of alcohol and other drugs. Fullerton (26) reports that attempts to implement some innovative programs in communities throughout the United States have failed simply because teachers were not well trained and did not use effective techniques which are an integral part of almost all newly developed curriculums.

Oregon is one of the states that has tried to educate teachers in the areas of alcohol and drug abuse. During 1970-1972, the Drug Education Program for Oregon Teachers (DEPOT) was funded by the federal government to provide 15 one-week (40 hour) drug education workshops for elementary, secondary, and college teachers. According to Dr. Schlaadt, the former director of DEPOT, all 15 drug education workshops were designed to:

* Provide teachers with a general understanding about the current drug scene.
* Implement the state handbook: Towards Responsible Drug Education, K-4, 5-9, and 10-14.
* Distribute available resource material.
* Stimulate local school drug education programs (including concern for persons having drug problems).

As a result of the DEPOT project, many teachers returned and started community drug projects.

The King County, Washington, Educational Service District (ESD) alcohol education curriculum project known as "Here's Looking at You," is a federally-funded (NIAAA,

Division of Prevention) alcohol abuse prevention model that has been in use since about 1976 (52, 80). The ESD curriculum project is now being replicated at several sites in the United States. It offers a school curriculum for grades kindergarten through 12 which can be used alone or integrated into existing curricula. This curriculum incorporates the current popular philosophy of alcohol education, which stresses both informational and attitudinal compcnents to promote decisions about the use or non-use of alcohol (6, 80). It combines alcohol information with exercises designed to enhance coping and decision-making skills and to clarify values and attitudes concerning the use or non-use of alcohol. This program focuses also on "self-esteem in an attempt to make students feel good about themselves and about their abilities." The kindergarten through three component of the ESD curriculum incorporates a non-alcohol-specific approach dealing, for example, with concepts like "how much is too much" (e.g., if drinking one cup of milk is good, is drinking ten cups of milk also good?). Tarnai et al. (80) reports that the teachers of "Here's Looking at You" curriculum are provided with a curriculum guide which lists specific teaching activities and projects for 15 hours of classwork at each grade level, and which contains a comprehensive reference section on alcohol information. Teachers are also provided with kits containing prepared

teaching aids, such as films, charts and instructional games, thus, relieving teachers of the task of developing or locating supplementary material (101, 80). Tarnai et al. (80) notes that although the curriculum can be used independently at any grade level, each year's activities are designed to build on those previous grades.

The ESD curriculum project, because of the importance of the teachers' role has devoted a significant portion of its time and resources to teacher training. This training is designed to be completed during a 32-hour inservice workshop which is usually held over a four-day period (80). Two staff trainers usually conduct the training for an average of 25 teachers per workshop.

In Alaska, the ESD alcohol education model has now been adapted to the unique needs of the Alaskan population and implemented on a statewide basis (80). Williams and Vejnoska (101) reported that while there are no data on the prevalence of drinking among youth, Alaskans believe that "the only hope they have for the future in regards to alcohol problems is to impact school age children" (101, p. 6). Alaska is a state characterized by a diverse ethnic composition and an uneven pattern of settlement. Among Native Alaskans, 60 percent of deaths are alcohol related, and this group accounts for 67 percent of all client admissions to state-funded alcoholism programs. Williams

and Vejnoska (101) reported that a broad base of Alaskans, from rural community members to state legislators, have fully supported the implementation of the ESD ("Here's Looking at You") curriculum in the Alaskan school systems. The Legislature appropriated $1.67 million for the implementation. By modifying certain parts of the curriculum, Alaskan officials have succeeded in making "Here's Looking at You" relevant to the experiences of the variety of ethnic populations located throughout the state of Alaska (101).

The Ombudsman Program (OP) is another notable program which has been approved as a national model by the U.S. Department of Education and is currently being disseminated nationwide. The OP write out is designed primarily for students in elementary, junior high and senior high schools. The overall program has three overlapping phases (69). The first phase dealing with self-awareness, involves a series of exercises which permit the student to gain a wider understanding of his or her particular set of values as an autonomous individual. Like the "Here's Looking at You" curriculum, the second phase of the OP deals with group skills and provides participants with an opportunity to develop their communications, decision-making and problem-solving skills which can, in some cases, be practiced in the immediate classroom environment (69).

During the third phase of the OP, students apply the insights and skills they have learned during the first two phases by planning and implementing a project within their own school or community. Sehwan (69), who evaluated the OP in Charlotte-Mecklenburg County in North Carolina in 1969, 1972, 1974, 1977 and 1979 cites the effectiveness of OP as follows:

1. The OP has shown more effectiveness when the regular classroom teachers have close interaction with the Ombudsman instructors;

2. The greater the time spent in "processing" Ombudsman exercises implemented during the course of the program, the greater the effectiveness of the OP;

3. As a human services program, the OP cannot be implemented on a uniform basis on all occasions. There are always human factors involved which cannot be controlled successfully (69, p. 27).

Another program that encompasses youngsters in grades kindergarten through 12 is the PRIDE program which is an integral part of the Comprehensive Health Education effort of the Dade County (Florida) schools. PRIDE stands for Professional Resources in Developmental Education. The program involves 250,000 youngsters, teachers, parents and numerous social agencies involved in a comprehensive approach to problem-solving, decision-making and personal growth. According to Don Samuels, the PRIDE program coordinator, there is a specialist in every junior and senior high school in Dade County (67). The specialist

assists instructors in obtaining materials necessary for the informational aspects of the program, counsels parents, refers and assists youngsters in getting into rehabilitation agencies should that be necessary, and organizes a variety of student involvement programs (67). The specialist is well trained and is able to train parents, teachers and students to interact in a positive way and to reach out to each other. Trained resource specialists recognize that teenagers generally can relate to others better than to anyone else. Specialists also understand peer pressures and train young people to act as peer counselors.

Don Samuels (51, 67) reports that more than 1,500 peer counselors have been trained in techniques of active listening, values clarification and decision-making skills. The program in a way is a giving and receiving experience. In the process of helping others, the counselors "are reinforcing their skills in interaction, becoming more aware of their own feelings and growing as they help others" (67). Some student counselors may elect to work with students at the elementary level and in many cases, have helped pave the way to junior high by making some of the "heavy" problems these youngsters face much lighter. Coordinator, Don Samuels (67) states that:

> The program recognizes that young people face a myriad of potential problem areas. Drug abuse is just one. So, while it includes drug information, it seeks to help young people develop to their optimum capability

> in all areas. Project PRIDE is a drug prevention program that rarely talks about drugs. Instead of pointing young people away from drugs, it points students towards themselves, towards feeling good about themselves and those around them (51, p. 36).

The PRIDE program gives students a chance to socialize, have fun, and enables them to find others to talk to whenever they want. There is a "rap room" in every secondary school, manned by trained peer counselors. The Yak Shack, Ziggy's Place, The Open Door, The Way Up, The Place, Aquarius, One Step Beyond and The Lighthouse are among the names given to some of the rap rooms located in all Dade's junior and senior high schools. Each resource specialist is responsible for having a rap room in his school. These rap rooms may be used on a drop-in basis by individuals, scheduled group activity or by an entire class wanting to experience different kinds of learning situations. One of the unique things about the PRIDE program is that events take place during school, after school, and in the evenings, depending on what students want.

Assisting teachers in working more "effectively and affectively with students is a part of the specialist's role" (67, p. 31). It may take place through workshops, or inservice, and parents may be involved as well. Some workshops take place in the evenings and this is mainly to enable parents to communicate better with their children and to understand their needs.

The PRIDE Program, in 1977, was operating at a cost of $1.2 million annually with local funds appropriated by the school board in Dade County upon the recommendation of the administration. According to Don Samuel (67), the PRIDE Program "has been nationally recognized by the President's Special Action Office on Drug Prevention for its adherence to the national philosophy of what drug prevention and education should be about."

In Oregon, the David Douglas School District (7-12) has implemented the ESD Curriculum ("Here's Looking at You"). There are several other special projects that have been operating within the state's school system. Among them are "Project Prevention" in the Chenowith School District in The Dalles, "Health Skills for Life" Program, Southern Oregon Drug Awareness (SODA), Comprehensive Options for Drug Abuse (CODA), "It's Your Choice" drinking and driving education project for youth, Prevention Integrated Service Model (PRISM), and Oregon Youth Traffic Safety Association at Oregon State University.

The Health Skills for Life project was developed through a Title IV-C grant from the Oregon State Department of Education. During 1981-1982, the Health Skills for Life Program was in the process of being implemented in grades kindergarten through eight in eight Oregon school districts. This program is a comprehensive health education curriculum,

kindergarten through grade 12. The program emphasizes lifelong skills for healthy life. There are 118 individual learning units (for kindergarten-12) each of which is centered on one specific health skill. Skills include actual health behaviors and involves planning, problem solving and decision making.

The Health Skills for Life Curriculum includes a grade-by-grade scope and sequence of essential health skills which are intended to help students develop a healthy lifestyle. One of the learning units was developed specifically to provide teachers with everything they need for the implementation of this program.

Health Skills for Life covers ten major areas of health which include growth and development, safety and first aid, disease prevention, dental health, fitness, environmental health, health services and consumer health, nutrition, and substance use and abuse. The units are comprehensive in nature and textbooks are not necessary although teachers may use them to supplement the program.

In Medford, Oregon, a group of 20 women (most of them parents) from the Junior Service League chose to deal actively with their deep concerns about alcohol and drug problems in their area. Their original plan was to bring to their annual community education series a speaker to talk to students and adults about drug abuse. The program which

began in 1981 and became known as the Southern Oregon Drug Awareness (SODA) was soon moved into schools in an attempt to reach a greater number of students. SODA was created with the following long-term goals:

1. To create an awareness of the substance abuse problems and to help in their solutions;
2. To provide support for and supplementary direction to Jackson County agencies that strive to create a positive environment in which to live; and
3. To eliminate all retail sales of drug-related paraphernalia in Jackson County.

The Oregon State Council on Alcoholism (OSCA) and the Property-Casualty Insurance industry, through the Western Insurance Information Service (WIIS) have designed a program known as "It is Your Choice." The purpose of this project was to educate Oregon youth about alcohol and driving. The project was also designed to reach all of Oregon's newly licensed young drivers and, if under 18, a parent, through one or more of the project components.

Literature is a major part of the project but with specific use or appeal to make it read and retained. A pamphlet directed at youth and entitled "Drinking and Driving -- It's Your Choice" carefully blends information through comic strip-type illustrations and brief statements or descriptions. The pamphlet has had two printings for a total of 150,000 copies and will go to all young, newly licensed drivers in Oregon shortly after receipt of their

Oregon driver's license. This will be accomplished with the cooperation of the State Motor Vehicles Division who is to provide names and addresses of this group of youth. "It's Your Choice" project now has some 50 volunteers throughout Oregon who promote and provide drinking and driving education to Oregon youth. These volunteers are trained prior to making their presentations. Crucial to this project is the kit of materials provided each volunteer speaker going into Oregon schools with the "It's Your Choice" material. According to Jean R. Shields, Administrative Planner, these kits are very comprehensive, and provides students with information on youth alcohol and drug problems, drinking and driving statistics and motor vehicle laws.

Prevention Integrated Service Model is a program which has been supported by a grant from the National Institute of Drug Abuse. This program focuses mainly on high-risk people and has been concentrated on high-risk target populations in some areas of Portland.

Oregon Youth Traffic Safety Association (OYTSA) is a program which began at Oregon State University about six years ago. It is funded by the Oregon Traffic Safety Commission 402 fund program. The purpose of this program has been to increase traffic safety awareness among young Oregon drivers by active involvement in comprehensive highway safety efforts. The goal of the OYTSA is to reduce the

number of youths involved in traffic accidents. The activities which OYTSA include are presentations on alcohol and safety belts, driver education, health clubs, and regional conferences for youth. The OYTSA works closely with local law enforcement agencies, student councils, driver education teachers, community leaders, and civic organizations.

The American Automobile Association (AAA) has developed, field tested, and evaluated the Alcohol Education and Traffic Safety Module for Elementary School, Kindergarten through Sixth Grade. According to the authors,

> the module has much content about use and misuse of alcohol grounded in the child's real world and conveyed through teaching techniques of demonstrated effectiveness with the groups involved.

Presentation increases in complexity by grade, each higher grade building on the activities and information of previous grades. Each module is planned for five sessions at each grade level (kindergarten-6) with approximately 30 minutes per session in kindergarten through three and increasing to 45 minutes per session by grades four through six.

There are many more alcohol and drug education programs that are now being developed throughout the United States. although most of these new programs have greatly improved in terms of philosophies, goals and objectives, their status and effectiveness has been unclear. Newer programs generally stress lifestyles, attitudinal and behavioral

changes which make them difficult to be objectively measured or evaluated. Furthermore, each program that is developed reflects to varying degrees the characteristics of the communities in which it was developed. Therefore, a community adopting a new program may need to ascertain whether or not the activities that it contains conform to local structure, ethnic background, socio-economic, and other characteristics.

CHAPTER III

RESEARCH METHODS AND DESIGN PROCEDURES

Introduction

This study sought to ascertain the overall status of alcohol, drugs, and traffic safety education in all Oregon schools. Principals of Oregon schools (kindergarten through grade 12) who responded to a questionnaire mailed to every school in Oregon provided the data for part of this study.

To obtain additional data and further check the validity of the information provided by the school principals, a personal interview involving 128 students, 47 teachers, and 44 parents was conducted in 16 randomly selected schools.

This chapter describes: (a) data collection instruments, (b) construction of the instruments, (c) selection of subjects and data collection procedures, and (d) treatment of the data.

Data Collection Instruments

Data collection instruments that would have been appropriate for the specific purposes of this study were not available. Therefore, two instruments were developed by the

researcher with one mailed to all principals in Oregon schools and the other was used in the actual interviews. These instruments (questionnaires), unlike all the other possible alternative methods, were seen as most effective and least costly in obtaining the necessary data from such an extensive population sample (school principals) within a limited time.

The first one was a three-page questionnaire that had a total of 19 items which sought information relating to teacher training, status of alcohol and drug education at each grade level, the extent of traffic safety education in relation to alcohol and drug abuse, types of programs and instructional methods currently being used, community attitudes toward supporting alcohol and drug education programs, community perception of the effectiveness of existing alcohol and drug education programs, and the future trends of alcohol and drug education in Oregon schools. This questionnaire (Appendix K) was mailed to all the school principals (1,400) in Oregon and was the main information base for answering the six central research questions listed in Chapter I. The purpose of the instrument was to obtain pertinent information related to alcohol and drug education from as many principals as possible within a limited time frame.

The second instrument (Appendix L) had 17 categories of questions and was designed to seek opinions from parents, teachers and students during the interviews conducted in 16 randomly selected schools. The results obtained from the interviews were used to amplify and check the validity of the information provided by the school principals.

Construction of the Instrument

Since no instrument was available that would satisfy the requirement of the study, an instrument was developed by the researcher to evaluate the status of alcohol and drug education in Oregon schools. At the early stage of the development of the questionnaire, the Alcohol Education Project Ad Hoc Committee met in the office of the Oregon Department of Education to provide input relating to the study methodology, development of research questions, and process of gathering data. The Ad Hoc Committee was made up of at least one member from each of the following groups:

Oregon Traffic Safety Commission
Oregon Department of Education
Oregon State Police
Mothers Against Drunk Drivers (MADD)
DUII Countermeasures Coordinating Council
Mental Health Department
Governor's DUI Task Force
Local School Districts
Oregon Youth Traffic Safety Association (OYTSA)
Department of Health, University of Oregon

As a result of this meeting, items were included in the questionnaire pertaining to the present status of alcohol and

drug education at each grade level, types of programs and instructional methods being used, and the future trends of alcohol and drug education in Oregon schools. In addition, the degree of emphasis placed on traffic safety aspects and the perceived attitudes of community members toward the program and its role in traffic safety was also an area of inquiry.

To ascertain the validity of the instrument, copies of the questionnaire developed subsequently were submitted for review to some of the members of the ad hoc committee which included members of the Oregon Traffic Safety Commission, a Health Education Specialist of the Oregon Department of Education, and two members of DUII Programming Coordinating Council.

Ten other individuals who reviewed the questionnaire included four professors from Oregon State University, three professors from the University of Oregon and three principals (possible respondents). Of the four professors from Oregon State University who reviewed the questionnaire, three of them were health instructors and one a specialist whose expertise was in research, statistics and evaluations. Three University of Oregon professors who reviewed the questionnaire were health instructors and one was also a specialist in research, statistics and evaluations. Their criticisms were analyzed, synthesized and implemented in the

final instrument. Each questionnaire which was sent to the principals of all schools in Oregon (kindergarten through 12) was coded to preserve anonymity and accompanied by a cover letter that stated the purpose and importance of the study.

Selection of Subjects and Data Collection

Principals of Oregon schools (kindergarten through 12) who returned usable, mailed questionnaires were the first group of subjects who provided information for this study. Additional information was obtained by interviewing a small sample (219 subjects) of parents, teachers and students.

Approximately 1,400 questionnaires were mailed out to Oregon schools on April 23, 1983. Recipients were asked to complete and return them by May 9, 1983. Preceding the questionnaires was a letter from Verne Duncan, State Superintendent, indicating the support of the Department of Education for the alcohol and drug education study (Appendix K). This letter was sent under separate cover prior to the mailing of the questionnaire. A letter of transmittal was also drafted by the researcher in conjunction with Len Tritsch, Health Education Specialist, indicating the purpose and the importance of the study. This cover letter (Appendix K) was sent with each questionnaire to every school principal. One of the items in the mail-out questionnaire

asked the school principals to rate the effectiveness of their alcohol and drug education programs. The responses solicited by this item helped to establish the basis for selection of schools that participated in on-site interviews. The desire was to randomly select 16 schools which included four from each of the four categories described below.

Following the return of the mail-out questionnaires, the schools that provided usable questionnaires were identified and divided into three categories based on how each of them responded to the item that asked them to rate the effectiveness of their program. The reason for dividing the schools into the above strata was to guarantee infcrmation from the spectrum of program quality.

Due to the fact that schools are required by law to provide alcohol and drug education, it was felt that some of the responses would be inflated. The individual interviews involving students, teachers, and parents could possibly validate or refute this fact.

The "high" category was made up of those schools whose principals perceived their program to be most effective compared to the programs of other schools. Those schools whose principals perceived them as operating a mediocre alcohol and drug education program were grouped into the "medium" category. A below average program rating placed

schools in the "low" category. An additional group, the "non-respondents," made up of those schools whose principals failed to return the questionnaires by the target date, became the fourth group.

From each of these four categories, four schools were randomly selected for on-site interviews using a table of random numbers. At least one instructional level (elementary, junior high and senior high) was selected from each category. Twelve of the 16 schools were public and four were non-public. In all, 219 subjects were interviewed; 47 teachers, 44 parents and 128 students. The interviews were conducted May 15 through June 6, 1983.

During the interviews in the 16 randomly selected schools, parents and students were selected from the student roster at random. The names were given to the principals who, in most cases, helped to arrange for interviews with parents and/or to set up areas or rooms in school where the students and teachers were interviewed. In some schools, however, the interviewing process was not as structured. This was due to the fact that school principals were overloaded with other time-demanding activities especially those involving graduation. Consequently, they were not able to help with interview arrangements such as retrieving students from their classrooms. In these situations, the interviewer selected students unassisted and at random between classes

and/or after school. Despite this difficulty, the researcher attempted in all cases to select students from cross-sections based on such variables as grade level, sex and race. The teachers also were selected at random and interviewed on school grounds. The majority of parents, in contrast, had to be interviewed during evening hours on the telephone because of work schedules. The names of the parents were randomly selected from the class roster disregarding whether or not their children were interview subjects.

All 219 subjects were interviewed by the researcher and an attempt was made to standardize the style of interview. A brief introductory statement explained the purpose of the study and its scope. The subjects were then told that: (a) a series of interviews were being conducted in several schools throughout Oregon to ascertain the status of alcohol and drug education; (b) their school, like 15 others, was selected at random; (c) their names or schools would not be revealed in the report or to anyone else; and (d) the interviewer would not ask any personal questions.

Initial analysis of the data did not reveal any substantial differences between the four categories in terms of program effectiveness. Therefore, no further discussion regarding categories is presented in Chapter IV.

Treatment of the Data

Questionnaire and interview data were processed by the Oregon Department of Education (ODE) Computer Services in Salem, Oregon. Both mail and interview questionnaire responses were entered directly into the computer by the ODE staff member. Accuracy was verified when a second operator repeated the entire entry process. Results were calculated using the Statistical Package for the Social Sciences (SPSS).

CHAPTER IV

ANALYSIS OF DATA

This study was conducted to assess the overall status of alcohol and drug education in Oregon schools. The degree of emphasis on traffic safety education in alcohol and drug curricula was also assessed. This chapter presents the findings of the study, and the analyses include data from both the mailed and interview questions.

On April 23, 1983, approximately 1,400 questionnaires were mailed out to Oregon schools (elementary through high schools). Of the 1,400 mail-out questionnaires, 686 (49%) were returned. Five hundred and eighty-three (42%) of these questionnaires were usable returns. The rest were eliminated from the analysis for being incomplete and/or inconsistent. Other questionnaires also excluded from the analysis were those in which code numbers had been removed by the respondents who did not want their identity known. The majority of the schools that provided information for the study, 515 (88%), were public schools and were over represented by about 12 percentage points. The rest of the schools that responded and returned usable data, 68 (12%), were non-public and were under represented by about 11 percentage points.

The majority of the junior high schools (60%) returned usable questionnaires. Approximately 37 percent of the high schools and 34 percent of the elementary schools provided usable data.

To obtain additional data and further substantiate the information provided by the school principals through the mail-out questionnaire, a personal interview was conducted in 16 randomly selected schools. The subjects interviewed included 128 students (K-12), 47 teachers, and 44 parents. Descriptive statistical measures were used to summarize and analyze the data obtained, both from the principals and interview subjects. Although a wide variety of items were used in gathering these data, their scope was designed to answer the following six research questions:

1) What is the status of alcohol and drug education in Oregon schools?

2) What is the extent of alcohol and drug abuse in comparison to traffic safety education?

3) What types of programs and instructional methods are being used?

4) What are community attitudes toward supporting alcohol and drug education programs?

5) How do communities perceive the effectiveness of alcohol and drug education programs?

6) What are the future trends of alcohol and drug education in Oregon?

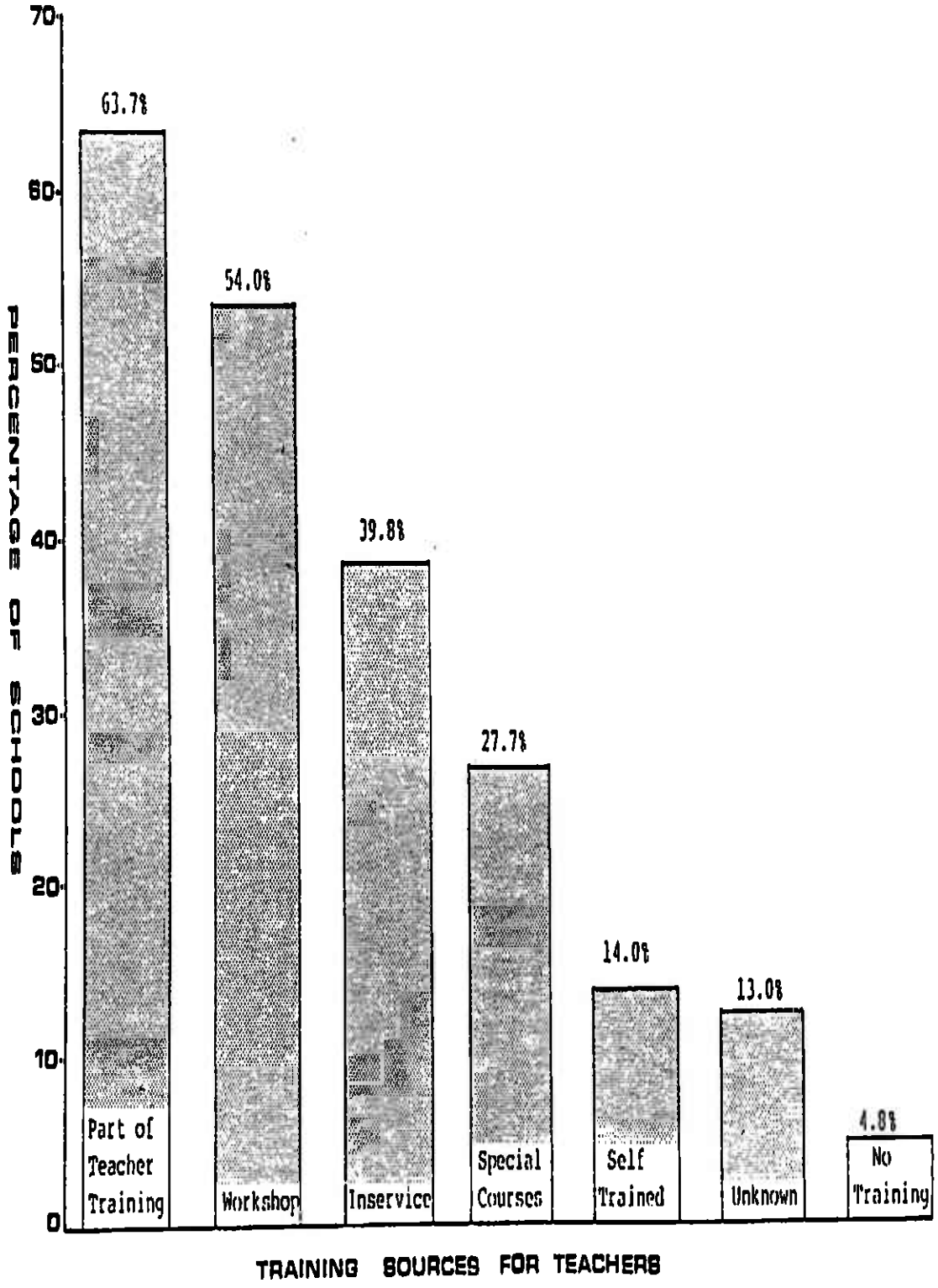
Some of the information provided by the mailed questionnaire and from the interviews were used to construct

the figures and tables found in this chapter. The actual number of schools involved in construction of Figures 1, 2a, 2b, 3, 4a, 4b, 5, 6, 7a and 11 are found in Appendices A, B, C, D, E, F, G, H, I, and J respectively.

Status of Alcohol and Drug Education in Oregon Schools

Four items (2, 5, 6 and 12) from the mail-out questionnaire (Appendix K) were relevant to the first research question (above) which sought information regarding the status of alcohol and drug education in Oregon schools. Specifically, these four questions yielded information on Teacher Training, Status of Alcohol and Drug Education at each Grade Level, Subject Areas in which Alcohol and Drug Education are integrated within each Grade Level, and the Degree of Emphasis placed on Different Aspects of Alcohol and Drug Education Programs.

Since the success of any educational program depends on the nature and quality of the information and also on the instructor's educational background, the training sources for the alcohol and drug education teachers in Oregon schools were examined. Presented in percentages in Figure 1 (Training Sources for Teachers), the results show that the majority of teachers, nearly two-thirds (63.7%) received their training as part of teacher preparation. More than half (54%) obtained their training from workshops and 39.8



TRAINING SOURCES FOR
ALCOHOL AND DRUG EDUCATION TEACHERS

Figure 1

percent from inservice training. These results indicate a relatively high reliance on institutional channels for teacher preparation in drugs and alcohol and are confirmed by the small percentage (14%) of teachers who considered themselves self-trained. However, the nature of this institutional training was not determined.

The basic elementary endorsement in Oregon requires completion of an approved teacher education program which includes at least one course in health education. A three hour personal health or methods course meets this requirement, but the coverage of alcohol and drugs in these courses at best may range from one to three hours. The standard secondary endorsement requires completion of 42 quarter hours of health education designed to develop teaching competencies through experience in areas which include personal health, nutrition, communicable diseases, and sexually transmitted diseases. Within these 42 quarter hours, there is no mandate for the exact amount of training time and depth of content in drug education. The University of Oregon requires all students to take a personal health course as part of graduation requirements. However, this course does not normally exceed three hours of alcohol and drug education coverage. Health education majors are required to take a one term drug education course. Oregon State University no longer requires students to take any

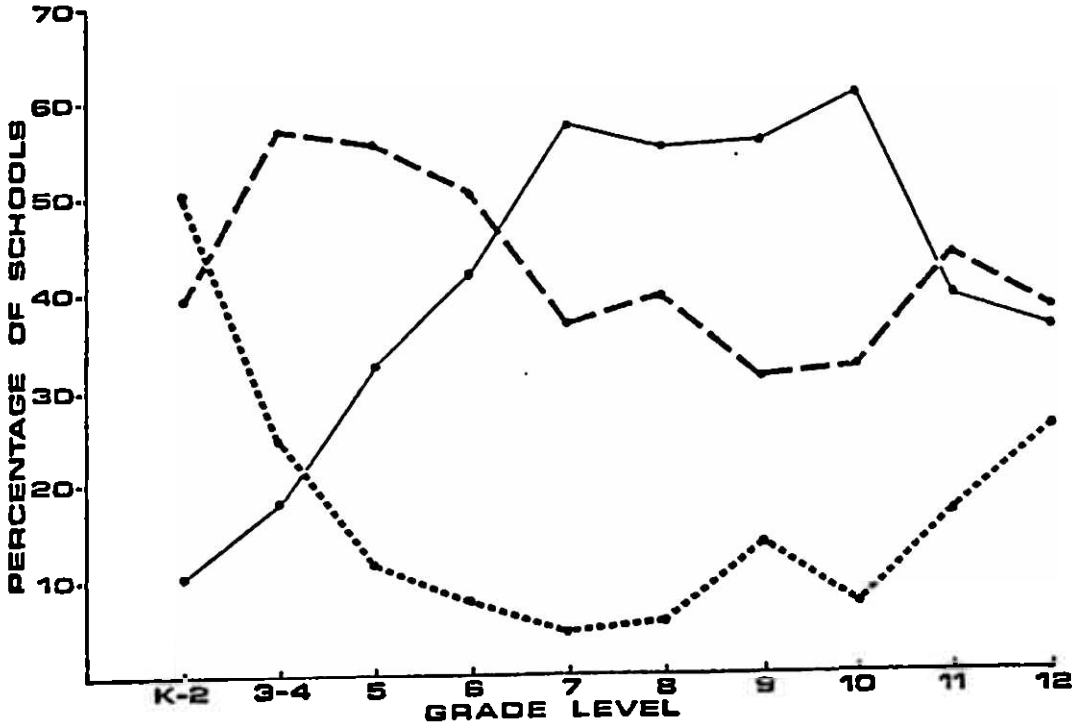
health education courses as a graduation requirement. Health education majors are required to take a one term drug education course.

The teachers in the self-trained category reported that their sources involved:

1) Local police
2) County health departments
3) Alcohol and drug treatment centers
4) Classroom guest speakers
5) Traffic safety groups
6) Organized groups, viz: Southern Oregon Drug Awareness (SODA), Mothers Against Drunk Drivers (MADD), Comprehensive Options for Drug Abuse (CODA), "It is Your Choice," and Youth Service Team
7) American Cancer Society
8) Resource materials, viz: books, newspapers, journals, pamphlets, and videotapes of televised specials
9) Material from commercial programs which include: Project Prevention, Health Skills for Life and "Here is Looking at You"

Of special note is the fact that nearly one in 20 teachers (4.8%) had no training in alcohol and drug education.

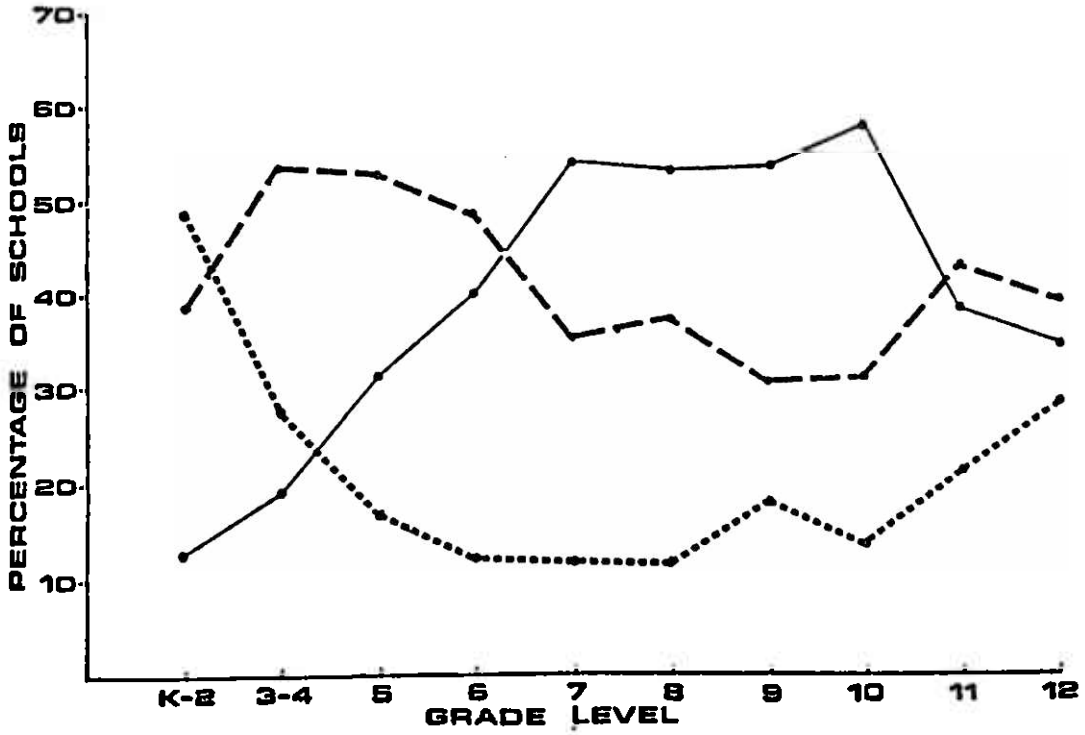
The analysis of the status of alcohol and drug education at each grade level in schools is presented in Figures 2a (Alcohol Education by Grade Level) and 2b (Drug Education by Grade Level). A comparison of Figures 2a and 2b shows that the percentages of schools teaching about alcohol and drugs are almost identical at each grade level. These data



ALCOHOL EDUCATION BY GRADE LEVEL

Figure 2a

Teaching taking place and required
Teaching taking place and not required
No teaching taking place



DRUG EDUCATION BY GRADE LEVEL

Figure 2b

suggest that schools are treating alcohol and drugs with equal importance in their educational curriculum.

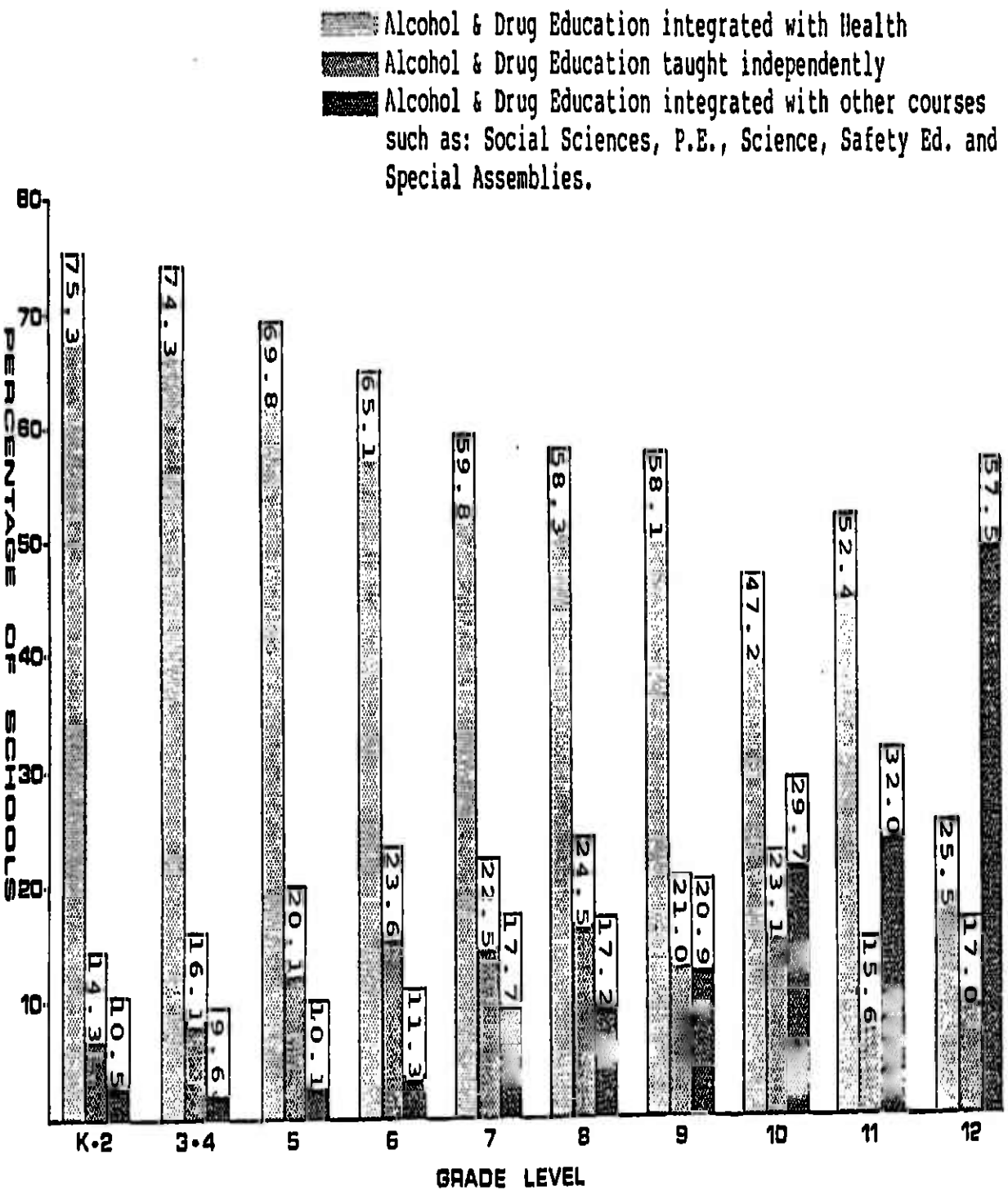
It appears that most education covering both alcohol and drug abuse, in the schools surveyed, took place between grades five and eight with the least amount of teaching in grades kindergarten through two, 11 and 12. It appears also that the greatest emphasis for traffic safety education was at grade ten. This coincided with the period of driver education classes in which students in some schools participate.

Fifty percent of the schools indicated that alcohol and drug education was not being taught in grades kindergarten through two. However, this proportion decreased gradually at higher grades and less than 20 percent indicated that no teaching was taking place in grades five, six, seven, and eight. The proportion of schools not teaching increased again gradually after grade nine and reached almost 30 percent in grade 12. Approximately ten percent of the schools reported that teaching was taking place in grades kindergarten through two and was required. This proportion increased gradually to approximately 60 percent in grade seven and remained about the same through grade ten where it decreased to about 38 percent in grade 12. The percentage of those schools which indicated that teaching was taking

place, but was not required, was much more consistent and fluctuated at around 42 percent across all the grade levels.

For the majority of schools, alcohol and drug education programs were integrated with the health education curriculum (Figure 3). An exception was in grade 12 where most of the alcohol and drug education was integrated with other subject areas. Approximately three-fourths (75.3%) of the schools integrated alcohol and drug education into the health education curriculum at the lower grade levels, kindergarten through four. This proportion diminishes steadily over the next three higher grades, dropping by about five percentage points at each grade level through grade seven. By the twelfth grade, only 25.5 percent of the schools reported that their alcohol and drug education was integrated with health. This 50 percentage point decrease was paralleled by an inclusion of alcohol and drug education in other courses, viz: social science, physical education, science and safety education, as well as into social assemblies. The highest point for this changed combination occurred at grade 12 where 57.5 percent of the schools were involved.

A minimal change occurs for independently taught alcohol and drug education courses in terms of absolute percentages for different grade levels (K-12). However, this proportion climbs steadily from 14.3 percent at kindergarten through



PERCENTAGE OF SCHOOLS COMBINING ALCOHOL AND DRUG EDUCATION WITH THE LISTED SUBJECTS AT EACH GRADE LEVEL

Figure 3

two, reaches its peak with nearly one-fourth of the schools (24.5%) at grade eight and drops again to 17 percent at grade 12. Between grades six and ten the proportions change very little, remaining close to the quarter mark.

An additional consideration in the analysis of current alcohol and drug education in Oregon schools is the objective of each program. The degree of emphasis placed on each of the six listed aspects of alcohol and drug education programs (Item #12 in Mailed-Out Questionnaire) is reported in Table 1. Health issues were identified as the major area of emphasis for both alcohol and drug education, placing 4.1 on a scale of one to five, with a five representing extensive emphasis. Providing factual information to the students was ranked second in priority. The two subject areas that received least emphasis were behavior change and alternatives to drug use. It should be noted, however, that all of the subject areas received relatively high scores since all were above 3.0 on a scale of one to five. Based on this information, all these seven aspects of alcohol and drug education received above average emphasis ratings.

Over 50 percent of the interview subjects in each of the three categories of parents, teachers and students (Table 2) reported that alcohol was the most commonly abused drug in their schools. Table 2 also shows that a greater percentage of teachers (76.1%) than parents (58.4%) and

Table 1

Degree of Emphasis Placed on Each of the Following Aspects of Alcohol and Drug Education Curriculum as Reported by the Principals

	Alcohol	Drugs
Health issues	4.1	4.1
Factual information	3.8	3.8
Knowledge conceptualization	3.6	3.6
Attitude change	3.6	3.6
Social issues	3.4	3.5
Behavior change	3.4	3.4
Alternatives to drug use	3.2	3.2

"1" represents Nonexistent
"5" represents Extensive

Table 2

The Most Commonly Abused Drugs in Schools as Reported by Parents, Teachers and Students

	Alcohol	Marijuana	Cocaine	Others
Parents	58.4%	36.0%	3.2%	2.4%
Teachers	76.1%	13.0%	0.0%	10.9%
Students	51.2%	48.8%	0.0%	0.0%

students (51.2%) reported that alcohol was the most commonly abused drug in their schools. Conversely, a greater

proportion of parents (36.0%) and students (48.8%) than teachers (13.0%) reported that marijuana was the most commonly abused drug. Almost half of the students felt that marijuana was the most abused drug in their school.

The Extent of Alcohol and Drug Education in Comparison to Traffic Safety Education

The degree of emphasis on traffic safety education in alcohol and drug education curricula was examined by items 4, 9, and 13 in the mail-out questionnaire, and item 3 in the interview questionnaire. Total number of schools with alcohol and drug education programs, their instructional methods and class time per grade level are subjects that were quantified. Overall, a large number of schools (63.3%) reported that their alcohol and drug education program dealt with traffic safety, specifically as related to drinking and driving. Proportionately, schools used the following methods in their traffic safety education programs:

- 19 percent integrated it with health education
- 12 percent used films and videotapes relating to traffic safety
- 8 percent integrated it with driver education courses
- 7 percent used outside speakers which included police personnel and traffic safety groups
- 6 percent used other safety programs (e.g., bike and pedestrian safety)
- 4 percent integrated it with social studies

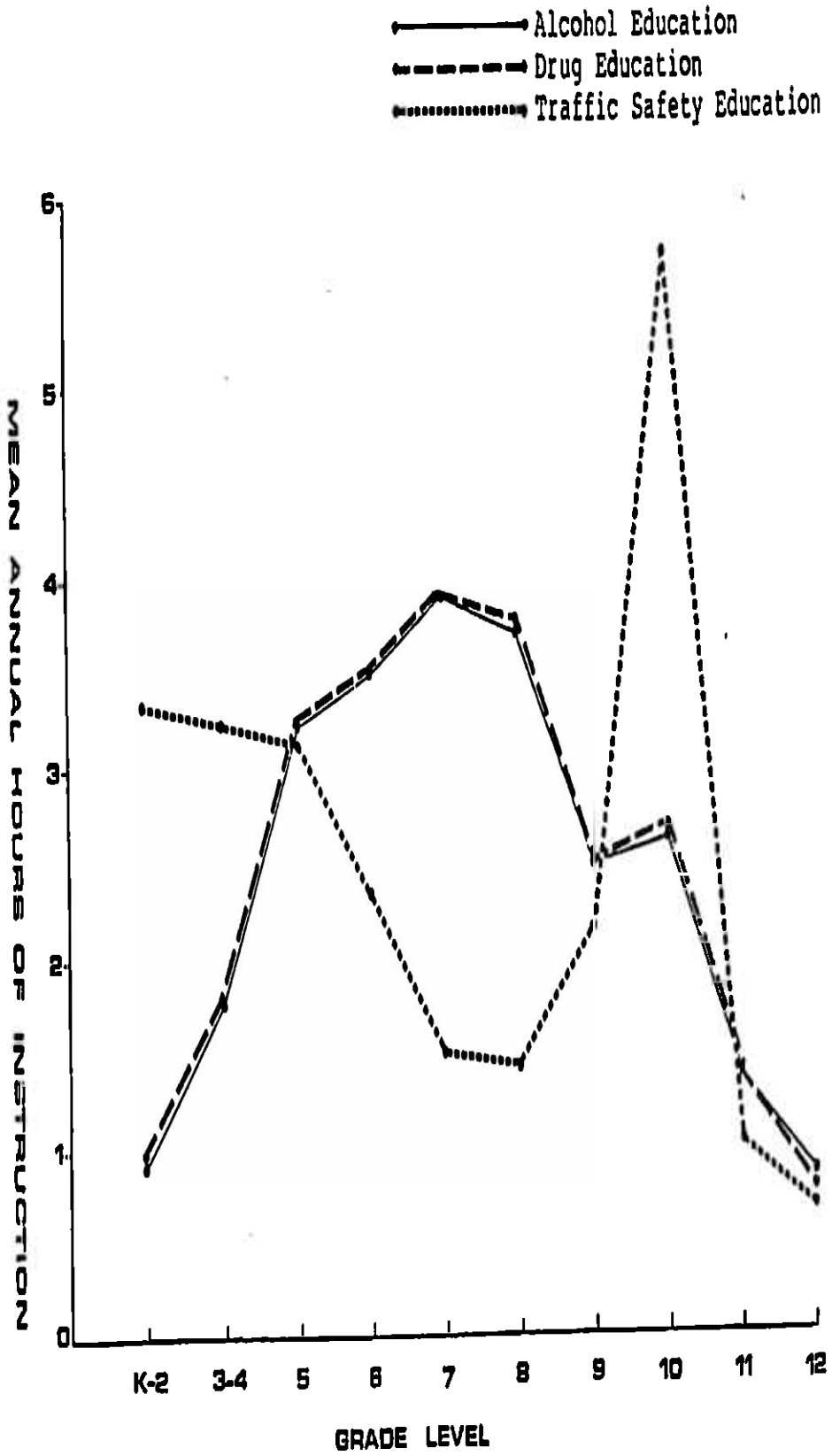
It should also be noted that some schools used a combination of the above in presenting traffic safety-related information.

The analysis of the average annual class time spent on alcohol, drug, and traffic safety education was approached from two perspectives. The average annual hours of instruction for each grade level as displayed in Figure 4a was obtained by dividing the total number of schools into the total number of hours devoted to instruction for each of the three areas (alcohol, drugs, and traffic safety).

Figure 4b displays the average annual class time of instruction for each grade level but excludes those schools which did not provide the specific number of hours of instruction.

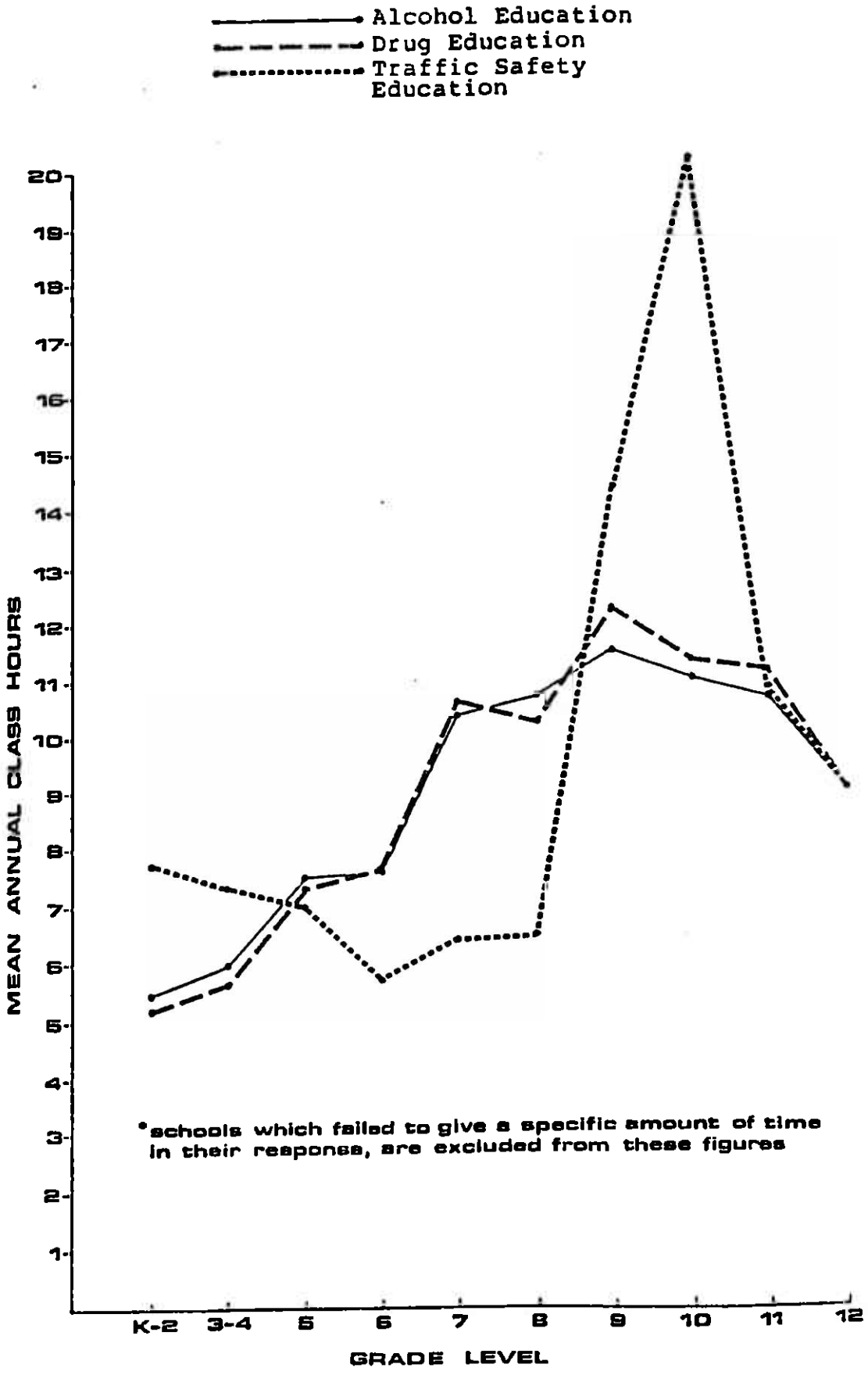
Figure 4a indicates that the emphasis on alcohol and drug education currently is between fifth and eighth grade and amounts to an average of 3.5 hours annually. The average annual class hours across all the grades (K-12) was 2.4 hours per year for each subject area (alcohol, drug, and traffic safety education). Traffic safety education received the greatest emphasis in grade ten (approximately six hours of class time annually).

Figure 4b indicates that the average amount of hours spent on alcohol and drug education followed a similar trend across all grade levels with the most emphasis taking place



OVERALL AVERAGE ANNUAL HOURS OF ALCOHOL, DRUG AND TRAFFIC SAFETY EDUCATION BY GRADE LEVEL

Figure 4a



AVERAGE ANNUAL CLASS HOURS REPORTED AT EACH GRADE LEVEL*

Figure 4b

in grade nine. The average annual class time spent on alcohol and drug education for grade nine was 9.1 hours.

The greatest emphasis in traffic safety education occurred in the tenth grade with the average annual class time of 20 hours. The average annual class time spent on traffic safety education across all grade levels was approximately 9.6 hours.

Of those schools that reported a specific number of hours, however, the picture is a little different. By excluding those schools that did not give a specific amount of time in tabulating values for Figure 4b, the average annual class hours spent on alcohol, drugs, and traffic safety education increased by at least twice the amount in every grade level (comparing the mean annual class hours displayed in Figures 4a and 4b). Comparison of Figures 4a and 4b further shows that the grades with the greatest emphasis on alcohol and drug education shifted from grades five through eight to grades seven through eleven.

The degree of emphasis placed on Driving Behavior and Accident Potential, Legal Aspects, and Pharmacological Aspects in the context of traffic safety education is shown in Table 3. Those values are based on a rating scale from one to five, "1" representing nonexistent and "5" representing extensive emphasis. Driving Behavior and Accident Potential received the greatest emphasis (Alcohol: 3.6;

Drugs: 3.5), followed by Legal Aspects (Alcohol: 3.2; Drugs: 3.1). Although Pharmacological Aspects appears to have received the least emphasis (Alcohol: 3.0; Drugs: 3.0), it should be noted that all three aspects of traffic safety education received high emphasis (above 3.0 average).

Table 3

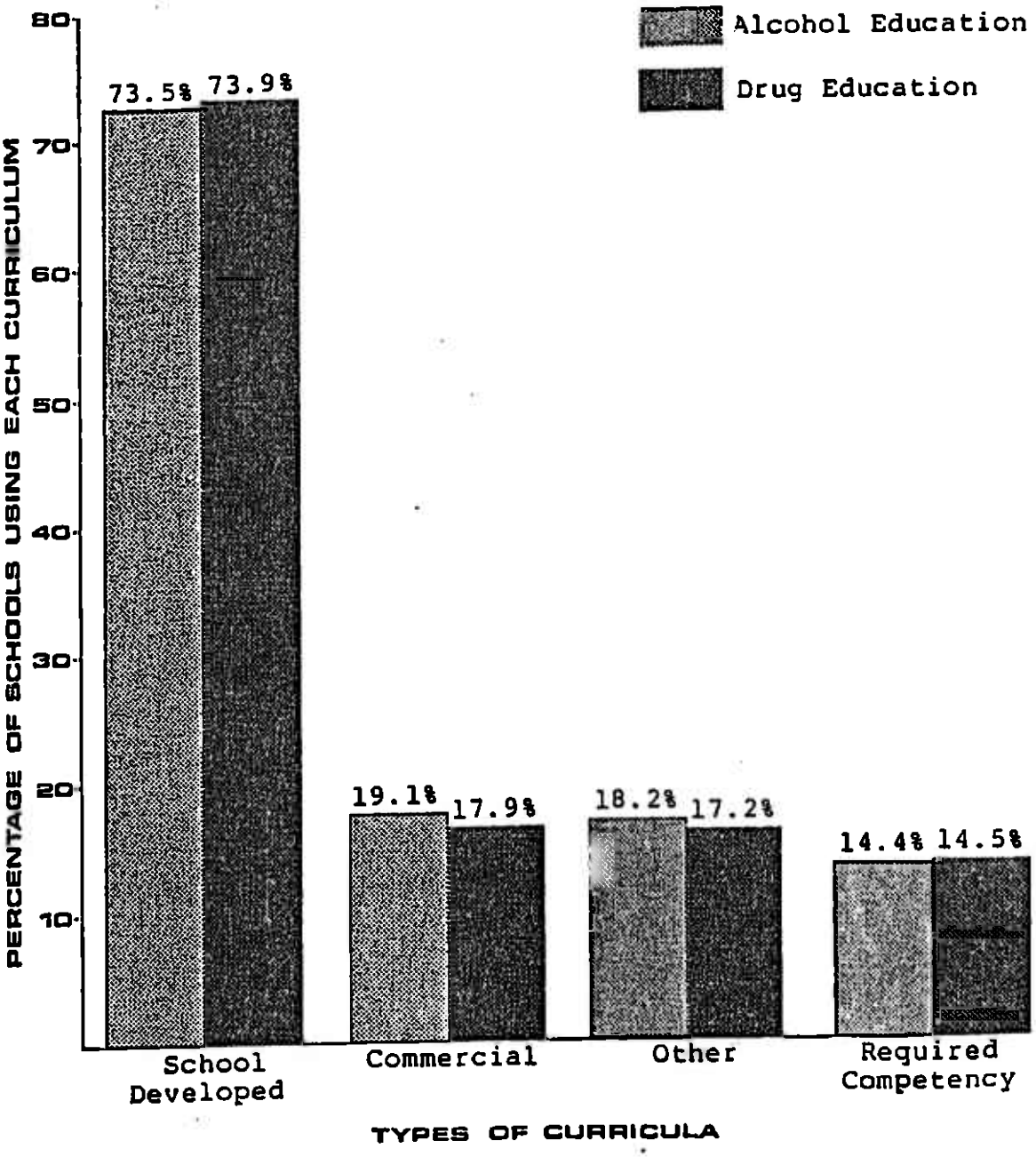
Degree of Emphasis Placed on Each of the Following Aspects of Traffic Safety as Reported by the School Principals

	Alcohol	Drugs
Driving Behavior and Accident Potential	3.6	3.5
Legal Aspects	3.2	3.1
Pharmacological Aspects	3.0	3.0

* "1" represents Nonexistent
"5" represents Extensive

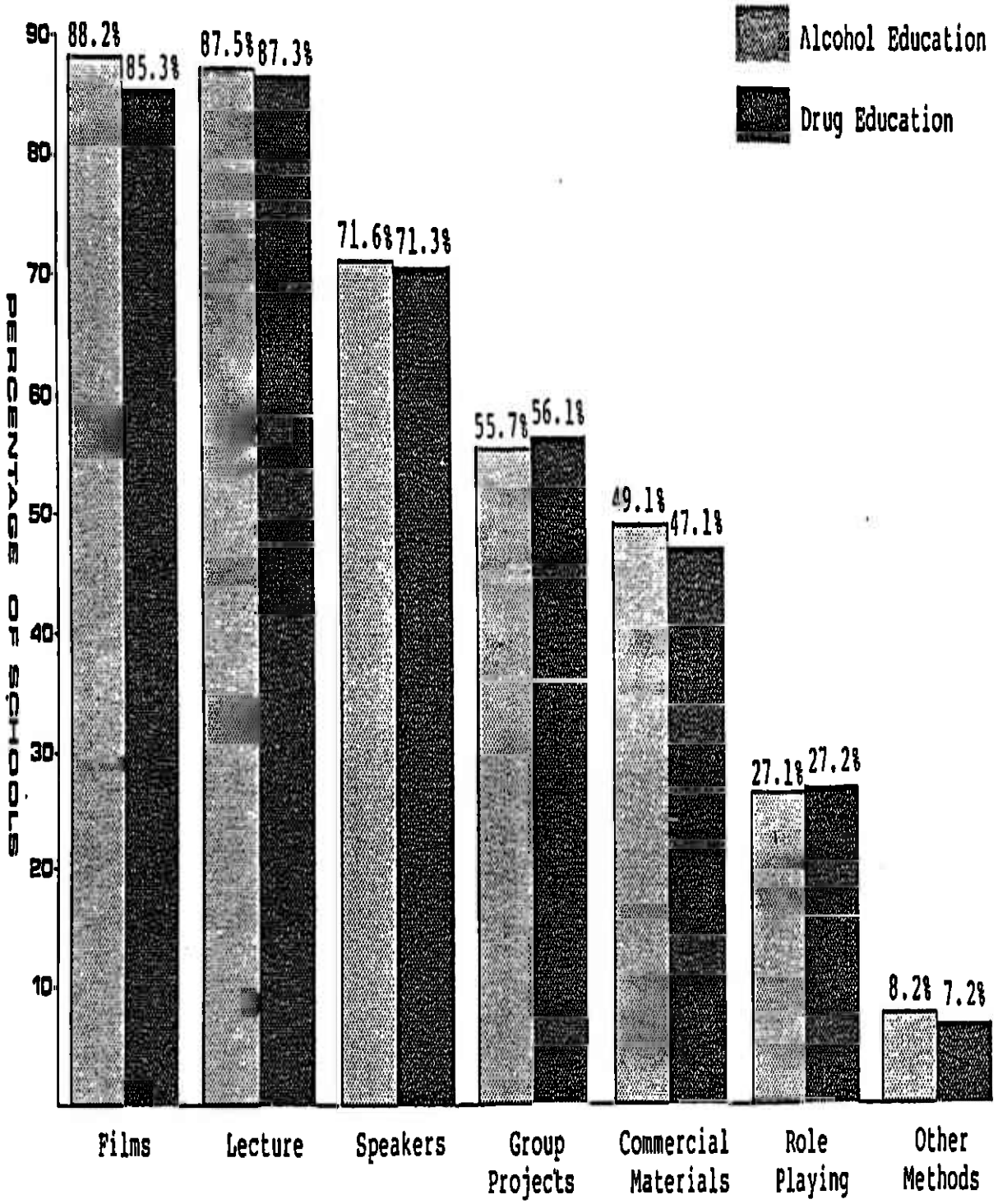
Types of Programs and Instructional Methods Being Used in Oregon Schools

For the analysis of the types of existing programs, items 7, 8, 10, and 15 of the mail-out questionnaire were relevant. The information solicited by those items centered on Types of Curricula (Figure 5), Instructional Methods (Figure 6), and Resources of Information (Figure 7a). An evaluation of contributing or hindering factors for the development and implementation of alcohol and drug education



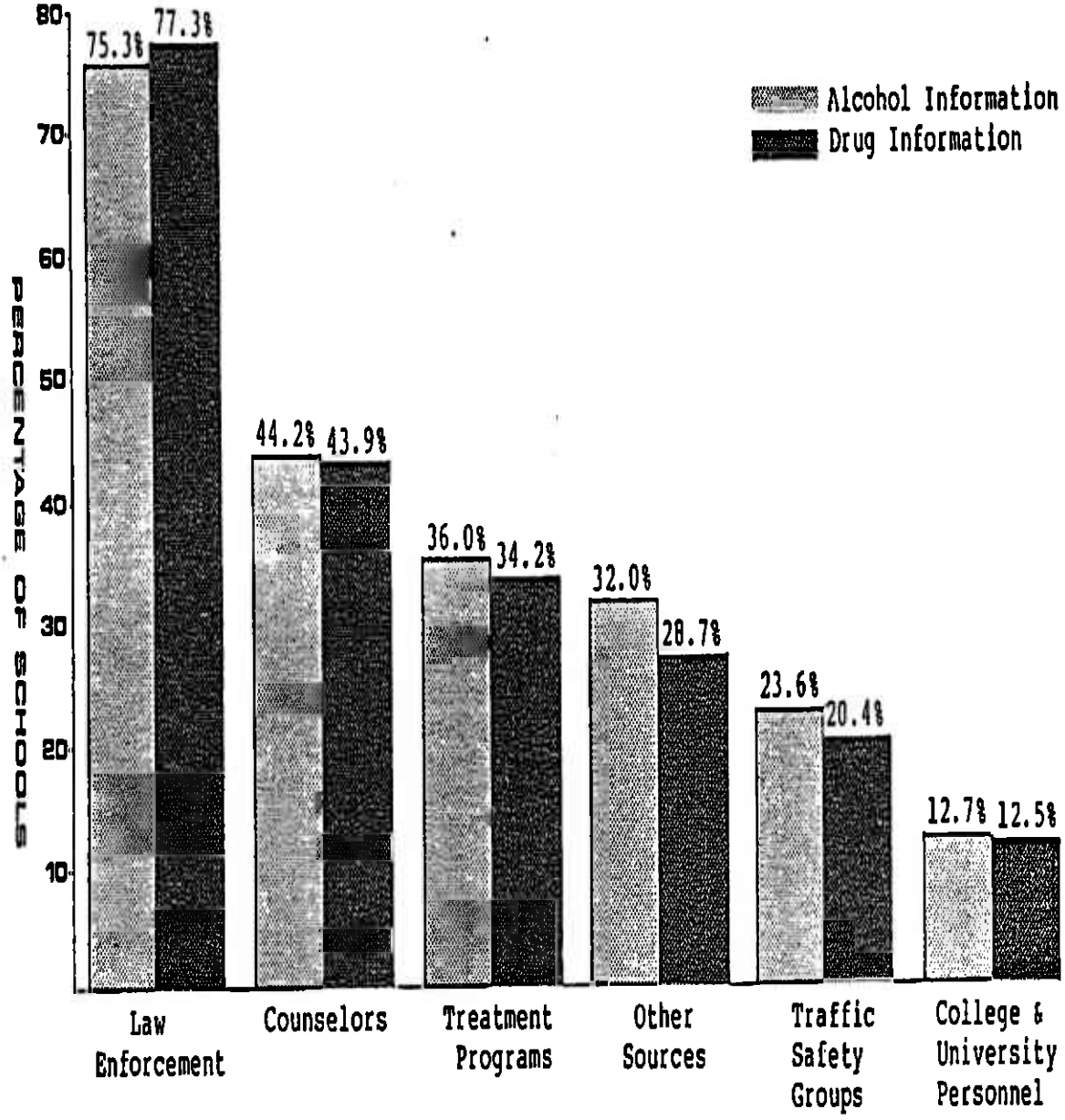
TYPES OF ALCOHOL AND DRUG EDUCATION CURRICULA BEING USED IN OREGON SCHOOLS

Figure 5



INSTRUCTIONAL METHODS FOR ALCOHOL AND DRUG EDUCATION

Figure 6



RESOURCE PERSONNEL PROVIDING SCHOOLS WITH ALCOHOL AND DRUG INFORMATION

Figure 7a

programs is presented in Table 4. Administrative support appears to be the major contributory factor in developing and implementing alcohol and drug education programs. Two factors which were cited as main obstacles in the development and implementation of those programs were lack of financial support and lack of qualified teachers. It is noteworthy that all five categories listed in Table 4 received above-average ranking (3.1-4.0) with nearly identical scores for both alcohol and drug education programs.

Table 4

The Degree to Which the Following Facets Have Promoted or Hindered the Development and Implementation of Alcohol and Drug Education Programs

	Alcohol	Drugs
Administrative Support	4.0	4.0
Availability of Resources	3.5	3.5
Community Support	3.4	3.5
Qualified Instructors	3.4	3.4
Financial Support	3.1	3.1

* "1" represents Hindered
"5" represents Promoted

The types of curricula used for alcohol and drug education in Oregon schools included: School Developed

Curriculum, Commercial Curriculum, Required Competency and "Others" which were not specified (Figure 5). By far the largest number, almost three-fourths of the 529 school principals who responded to the relevant item used school-developed curricula for both alcohol and drug education programs; 73.5 percent and 73.9 percent respectively. The percentages of schools using commercially developed curricula were substantially lower (Alcohol: 19.1%; Drugs: 17.9%). Almost 15 percent of schools used competency requirements as a basis for curricula (14.4% for alcohol education and 14.5% for drug education). Those schools that reported using curricula other than those already described were 18.2 percent for alcohol education and 17.2 percent for drug education. The nature of these curricula was not specified by the respondents.

Most schools surveyed reported using a combination of instructional methods. As shown in Figure 6, these methods included films, lectures, outside speakers, commercial materials, role playing and other methods. For each one of these methods, the percentage difference between the two educational programs (alcohol and drugs) were quite small (from .3 to 3.1%). For the most part, films, lectures and speakers emerged as the favored program components in alcohol and drug education curricula in Oregon schools. Figure 6 shows that films and lectures dominated as methods

of choice in nearly 90 percent of the schools. Films had the highest share in that they were used by 88.2 percent of the schools in alcohol education and 85.3 percent in drug education. The percentages of schools using lecture-based instruction were almost as high (87.5% for alcohol and 87.3% for drug education). The nature of the two least used instructional methods (Role Playing and "Other" methods) was not specified. It should be noted that because of multiple responses, the percentages displayed in Figure 6 add up to more than 100.

The resources which provided schools with alcohol and drug-related information included Law Enforcement, Counselors, Treatment Programs, "Other" sources which were not specified, Traffic Safety Groups, Colleges and Universities. Since the percentages in Figure 7a do not add up to 100, it is fair to assume that schools use multiple sources for their alcohol and drug education programs. However, law enforcement agencies appear to be a primary source. Approximately three out of four schools checked law enforcement personnel as an information source with 75.3 percent indicated for alcohol and 77.3 percent of the schools for drug-related information.

Counselors provided alcohol-related information for 44.2 percent of the schools and drug-related information to 43.9 percent of the schools. Colleges and universities were

ranked the lowest in spite of the fact that they ranked the highest in the teacher preparation for alcohol and drug education. Barely 13 percent of the schools relied on colleges and universities as information sources for their current program.

Community Attitudes Toward Supporting Alcohol and Drug Education Programs

To determine community attitudes toward the support for alcohol and drug education programs, items 11 and 14 in the mail-questionnaire and item 9 in the interview questionnaire sought information on Community Attitudes, Program Importance and Effectiveness, Perceptions of Program Objectives and Appropriate Places for Teaching about Alcohol and Drugs. Principals were asked to rate their communities in the areas of Support for their Schools, Concern for Alcohol and Drug Abuse, Concern for Youth Delinquency, Drunk Driving and Traffic Safety. These ratings were based on a scale of one through five with a "1" representing low and a "5" representing high. The results in Table 5 illustrate that the principals rated their community highest in support for their schools (4.0). The community's concern for drug abuse was ranked second (3.8) by the principals and drunk driving and traffic safety fourth (3.5). Alcohol abuse was last in this ranking. However, there was no substantial difference since all were within a one-point scale (3.0-4.0). This

suggests that the principals' perceptions were that their communities may equally be concerned about these five areas (Table 5).

Table 5

Principal Ratings of Their Communities in the Following Areas

Support for Their School	4.0
Concern for Drug Abuse	3.8
Concern for Youth Delinquency	3.6
Concern for Drunk Driving and Traffic Safety	3.5
Concern for Alcohol Abuse	3.4

* "1" represents Low
"5" represents High

Table 6 represents the principals' perception of how community and school groups would rate the importance of alcohol and drug education programs in schools. The principals rated themselves highest as members of their communities who supported alcohol and drug education programs in schools (4.5). Principals also perceived that teachers and non-school professionals would be supportive to having a drug education program in school. The results in (Table 6) indicate that students, as viewed by the principals, do not feel strongly that a drug education program is an important part of school curricula.

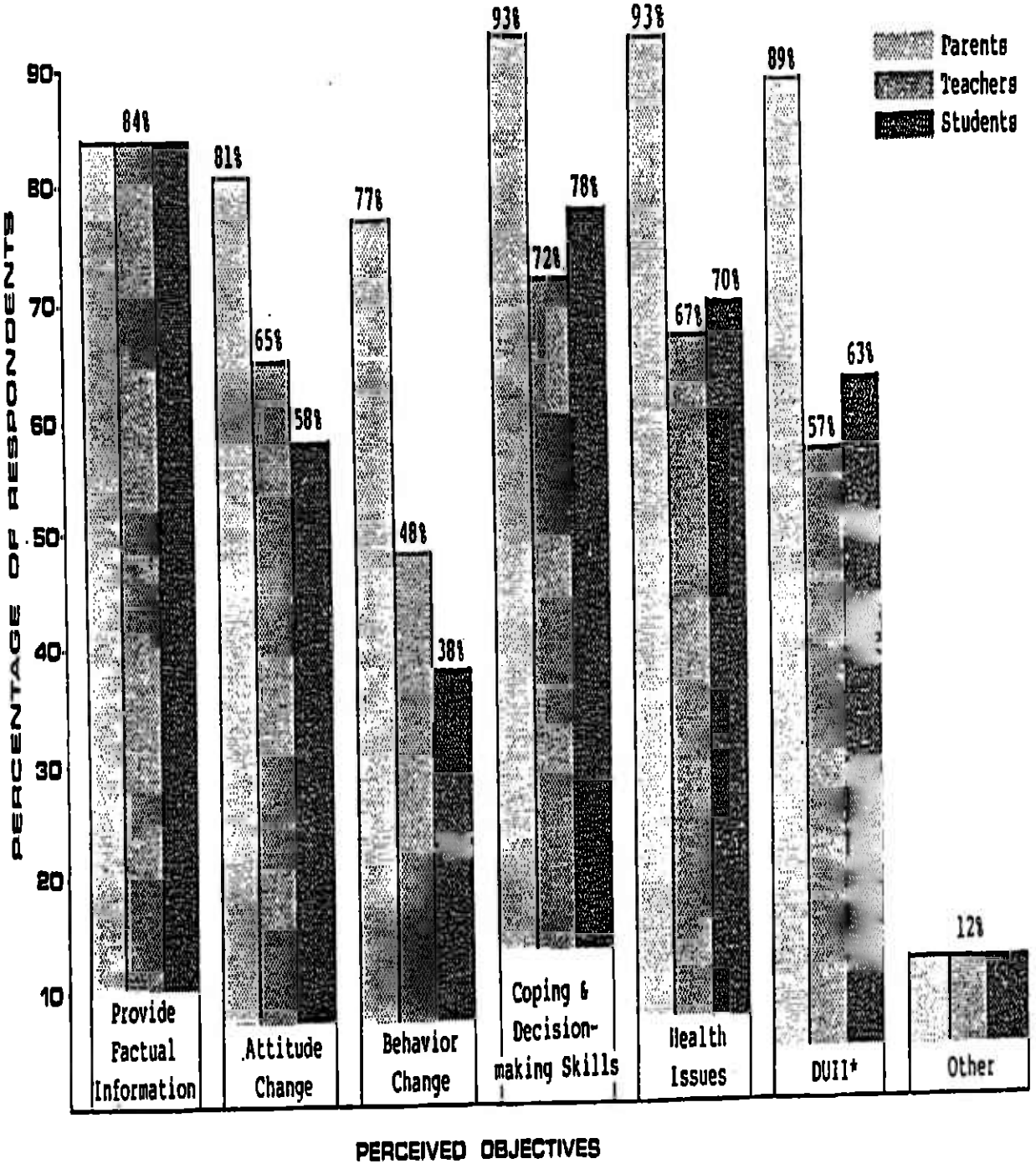
Table 6

Principals' Perception of How Community and School Groups Would Rate the Importance of Alcohol and Drug Education

	Alcohol	Drugs
Principals Themselves	4.5	4.5
Teachers	4.2	4.2
Non-School Professionals	4.1	4.1
Parents	3.8	4.0
Community	3.8	4.0
Students	3.4	3.5

* "1" represents Low
"5" represents High

Figure 7b represents the ideal objectives in alcohol and drug education as perceived by parents, teachers and students who were interviewed. Except for the category of Provision of Factual Information, parents, teachers and students differed substantially, though not consistently, in what they felt were the ideal objectives of alcohol and drug education programs. The parents considered the three most important objectives of an alcohol and drug education program to be Coping and Decision Making Skills (93%), Health Issues (93%), and Driving Under the Influence and Traffic Safety (89%).



*DUII: Driving under the influence & Traffic Safety

IDEAL OBJECTIVES IN ALCOHOL AND DRUG EDUCATION AS PERCEIVED BY PARENTS, TEACHERS AND STUDENTS

Figure 7b

The three objectives considered by teachers to be most important were Provision of Factual Information (84%), Coping and Decision-Making Skills (72%), and Health Issues (67%). Students considered the Provision of Factual Information (84%), Coping and Decision-Making Skills (78%), and Health Issues (70%) to be the three most important objectives. Of special note is the fact that only 48 percent of teachers and 38 percent of students felt that behavioral change would be an ideal objective in alcohol and drug education programs. Compared to teachers and students, the percentage of parents supporting each objective was consistently higher (above 77%).

Community Perception of Effectiveness of Existing Alcohol and Drug Education Programs in Schools

Although desirable, it was not possible because of time constraints to interview community members in every school district to find out how they viewed the effectiveness of existing programs. Instead, the principals of all the schools throughout Oregon were asked to indicate how they and groups in their communities would rate the effectiveness of existing alcohol and drug education programs. Items 14 and 16 in the mail-questionnaire investigated the importance and effectiveness of alcohol and drug education programs from the principals' point of view. Table 7 shows that the

principals ranked their own perceptions of the effectiveness of their operating programs above the perception of other community and school groups and, in fact, rated parental and community perceptions the lowest (2.9). Similar results were obtained when parents, teachers and students were interviewed. The interviews revealed that 74 percent of the teachers felt that their existing programs were effective, whereas, only 49 percent of the students and 42 percent of the parents shared that opinion.

Table 7

Principals' Perception of How Community and School Groups Would Rate the Effectiveness of Existing Alcohol and Drug Education Programs

	Alcohol	Drugs
Principals Themselves	3.2	3.2
Teachers	3.2	3.2
Non-School Professionals	3.0	3.1
Students	2.9	3.0
Parents	2.9	3.0
Community	2.9	2.9

* "1" represents Low
"5" represents High

While the principals generally felt that existing programs were effective, they conceded that teachers were

not necessarily seen as the most reliable sources of alcohol and drug information by students. Table 8 illustrates that point in ranking peers as the most reliable sources of alcohol and drug information as viewed by students.

Table 8

Principals' Perceptions of How the Students View the Following People as Reliable Sources of Alcohol and Drug Information

	Alcohol	Drugs
Peers	3.9	3.9
Clients of Rehabilitation	3.8	3.8
School (Teachers and Counselors)	3.6	3.6
Law Enforcement Officials	3.4	3.4
Parents	2.8	2.7

* "1" represents Low
"5" represents High

Further analysis of these results reveals that principals thought that students would rank law enforcement (3.4) and parents (2.8) as the least reliable sources of information. About nine out of ten (88%) of the people interviewed in this study also felt that peers, unlike any other group, strongly influence students to use drugs.

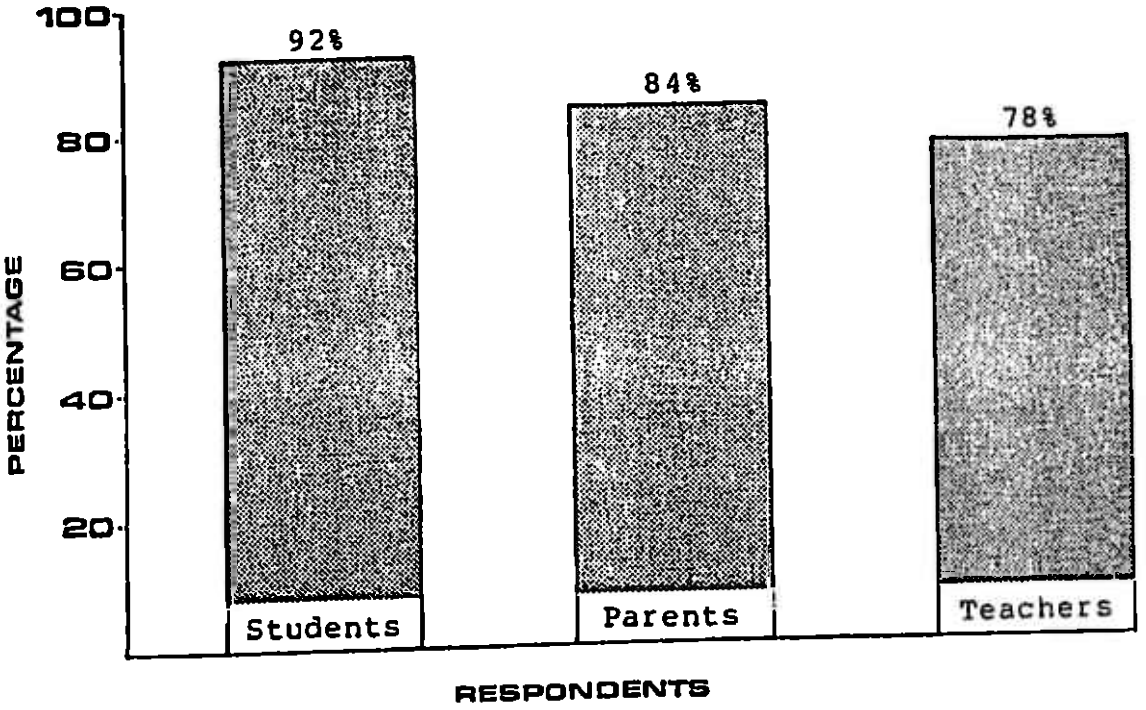
Unlike principals and teachers, parents and students felt that existing programs have had little impact on

teenage drinking and their drunk driving. The study found that 88 percent of all the people interviewed thought there was a significant number of students who drove a car while under the influence of alcohol and/or other drugs. About the same number (89%) felt that teenage drinking was significantly contributing to traffic safety problems and ten percent felt that the problem was extremely serious.

Future Trends of Alcohol and Drug Education in Oregon Schools

A large number of items probed areas associated with future trends of alcohol and drug education in Oregon. Items 17 through 19 in the mail-out questionnaire and items 9 through 13, 14, 16 and 17 in the interview questionnaire (posed to parents, teachers and students) revealed strong support for alcohol and drug education in Oregon schools (Tables 4, 5 and 6). Over 75 percent of the subjects in each category (parents, teachers and students) thought the school to be the most appropriate place for alcohol and drug education (Figure 8). The majority of people interviewed felt that no other educational arena could reach such a large audience. Furthermore, these respondents supported beginning alcohol and drug education early, starting at elementary grade levels (Table 9).

All the parents interviewed felt that alcohol and drug education should start before grade nine. The largest



PERCENTAGES OF STUDENTS, PARENTS AND TEACHERS WHO FEEL THAT SCHOOL IS THE MOST APPROPRIATE PLACE FOR ALCOHOL AND DRUG EDUCATION

Figure 8

Table 9

Percentages of Respondents Favoring Grade Levels at Which Alcohol and Drug Education Should Begin

Respondents	Place of Education and/or Grade Level in School													
	Home Educ.	K	1	2	3	4	5	6	7	8	9	10	11	12
Parents	9.1	27.3	16.0	2.3	9.1	9.1	16.0	7.0	2.3	2.3	0	0	0	0
Students	2.3	1.6	6.3	3.1	10.2	12.5	21.1	16.4	16.4	4.0	4.0	1.6	.80	2.3
Teachers	10.6	17.0	17.0	0	10.6	6.4	21.3	10.6	4.3	0	2.1	0	0	0

percentage (43.3%) was in favor of starting alcohol and drug education in kindergarten and grade one (27% and 16% respectively). Another 16 percent of the parents favored starting it in grade five. The majority of teachers favored starting alcohol and drug education in grade five (21.3%). An additional 17 percent of the teachers favored kindergarten and still another 17 percent favored grade one. Although the largest percentage (21.1%) of students felt that alcohol and drug education should begin in grade five, the majority favored starting it in grades five, six or seven (Table 9).

Of special note is the fact that 84 percent of the persons interviewed (parents, teachers and students) felt that traffic safety education should be combined with alcohol and drug education. The majority of these respondents felt that since use of alcohol and other drugs affect driving, these issues should be dealt with together to enable students to understand how they interrelate.

Some of the principals who responded to the open-ended questions (#17 and #19) in the mail-out questionnaire and also some of the subjects interviewed felt that overall curriculum improvement cannot be achieved through crash programs or patchwork approaches. These respondents stressed the importance of cooperative action and stated that support from the state, the entire community and all of

its specialized resources is necessary in order to assist local school systems in the improvement of alcohol and drug education.

The principals identified special needs which would have to be met in order to upgrade their alcohol and drug education curriculum. Provision of resources and teacher training were prominently mentioned (Table 10).

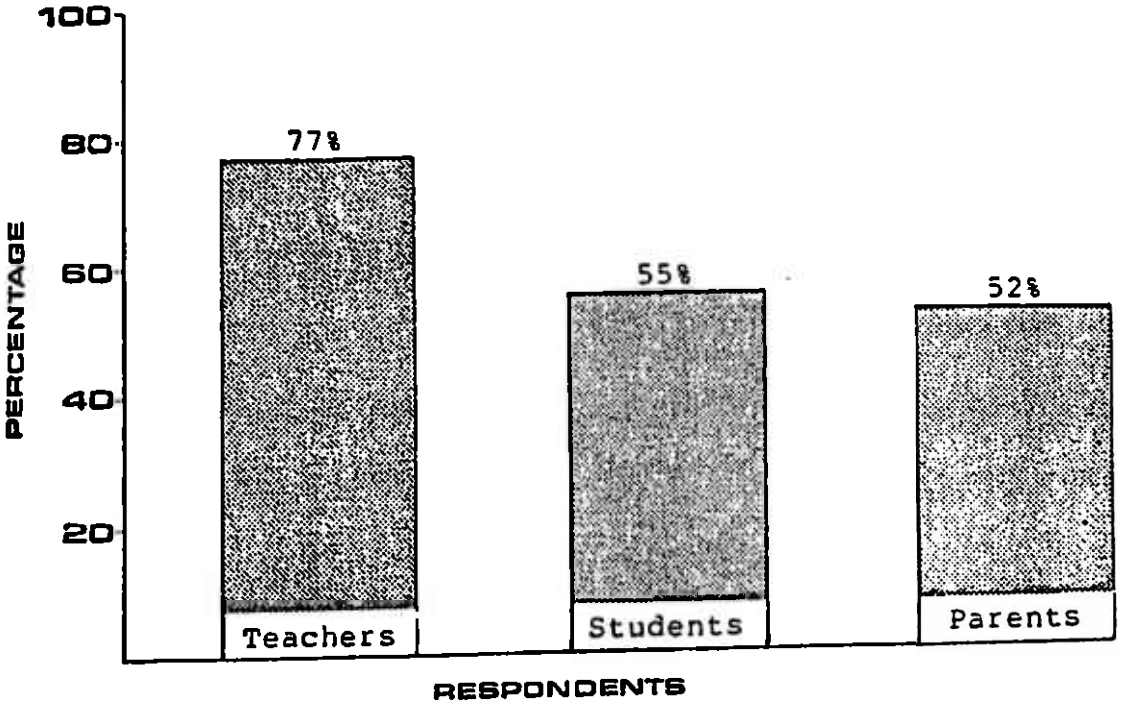
Many parents, teachers and a small number of students who were interviewed for this study felt that a comprehensive kindergarten through 12 alcohol and drug education program is necessary in order to achieve impact on youngsters at all grade levels. At least 80 of the principals who responded to the mail-out questionnaire made a similar suggestion.

During the interview, 77 percent of the teachers indicated that their schools had alcohol and drug education programs but only 55 percent of the students and 52 percent of the parents were in agreement (Figure 9). When asked whether or not the existing programs have been effective, 77 percent of the teachers felt that the programs were effective, whereas only 49 percent of the students and 42 percent of the parents felt the same (Figure 10). More than 50 percent of parents and students felt that the programs were not effective.

Table 10

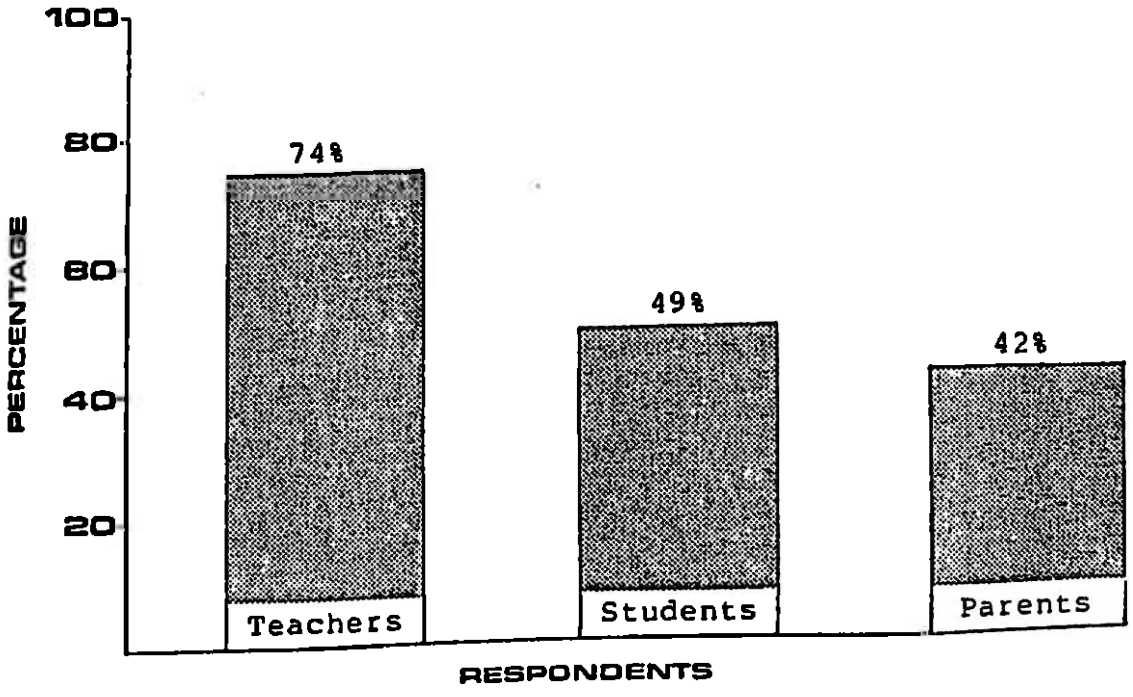
Special Needs Identified by School Principals

Needs	Number of Schools Making Suggestions
1. Provision of Resources	
a) Updated Films	60
b) Instructional Units Written Specifically for Teachers ("Cookbook" type teaching guides)	40
c) Monthly Publication	30
d) Standardized and/or Stage Approved Text	20
2. Teacher Training	110
3. Community Support	88
4. Allocation of Time for Alcohol and Drug Education with School Curriculum	73
5. A Comprehensive K-12 Grade Alcohol and Drug Education Program	72
6. Financial Assistance	72
7. Speakers with Specialized Skills	56
8. Stricter Law Enforcement	33
9. District and/or Administrative Support	32
10. Use of Rehabilitated Former Drug Users in Classroom Situations	21
11. Televised Programs for Parents and Children to Watch at Home	12



PERCENTAGES OF TEACHERS, STUDENTS AND PARENTS INDICATING THAT THEIR SCHOOLS HAVE ALCOHOL AND DRUG EDUCATION PROGRAMS

Figure 9

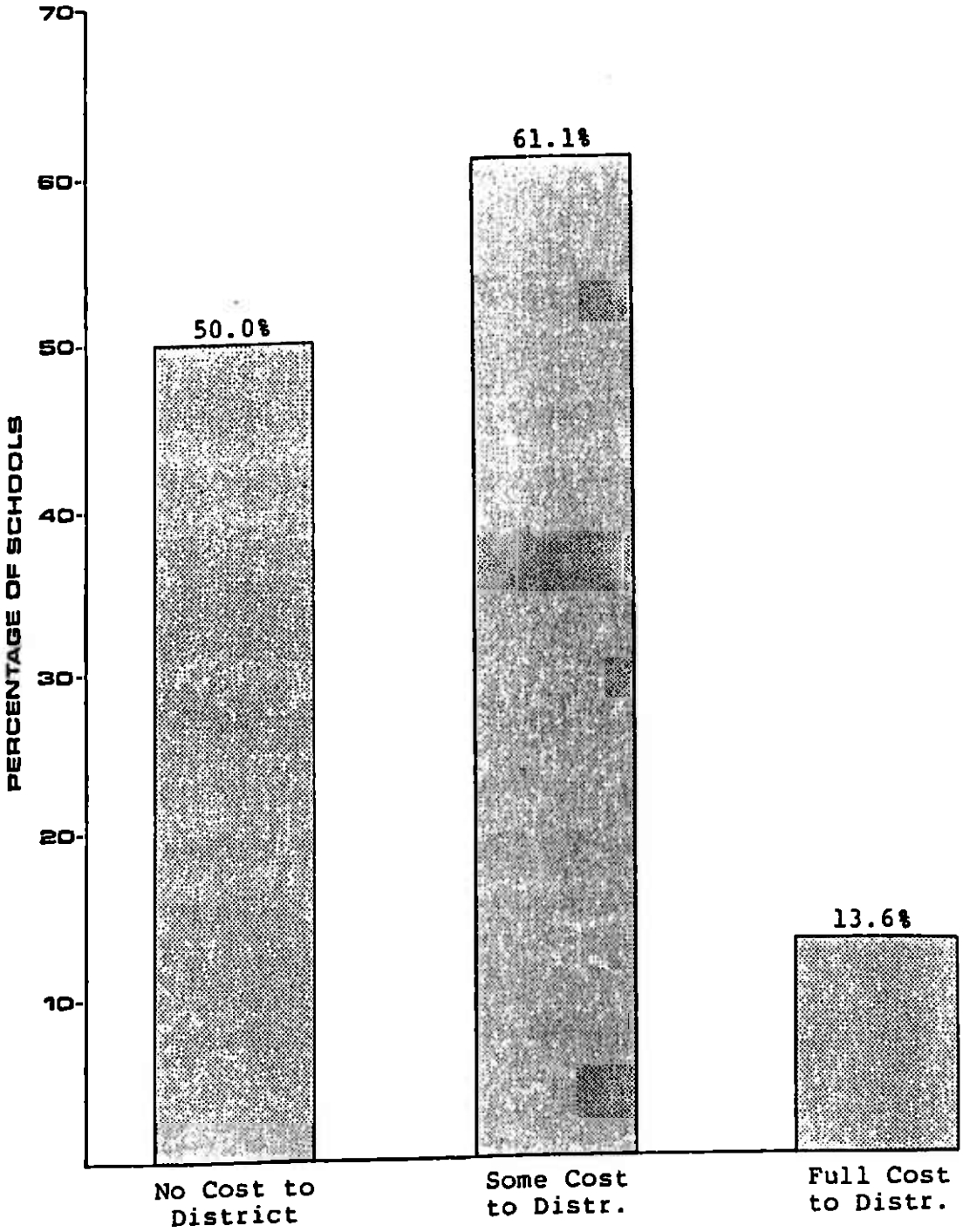


PERCENTAGES OF TEACHERS, STUDENTS AND PARENTS WHO FELT THAT THE EXISTING ALCOHOL AND DRUG EDUCATION PROGRAMS HAVE BEEN EFFECTIVE

Figure 10

About six out of ten (61.1%) of the principals who responded to the relevant questions indicated that their schools would be willing to implement a proven effective program if one was made available and if financial support was provided (Figure 11). During the interview in 16 randomly selected schools, 77 percent of parents, teachers and students interviewed were in agreement with the principals.

At least 13 percent of the principals and nine percent of parents, teachers and students indicated that they would be willing to implement a proven effective program, even if financial support was not provided.



FINANCIAL CONDITIONS UNDER WHICH SCHOOLS WOULD BE WILLING TO IMPLEMENT A PROVEN-EFFECTIVE PROGRAM IF ONE WERE MADE AVAILABLE

Figure 11

CHAPTER V

SUMMARY, CONCLUSION, DISCUSSION AND RECOMMENDATIONS

Research studies and related literature examined in Chapter II indicate that alcohol and drug abuse has reached epidemic proportions and continues to increase. The findings in Chapter II further suggest that an urgent need exist for youth and the public, at large, to be properly educated about alcohol and drug abuse. To this extent, schools could and should play a more important role in providing effective alcohol and drug abuse prevention programs.

The purpose of this study was to evaluate the present status of alcohol and drug education in Oregon schools and the extent of traffic safety education in relation to it. This chapter is divided into the following four sections: 1) summary of the problem and procedures, 2) conclusion, 3) discussion, and 4) recommendations for future actions.

Summary

Instruments for the mail survey and interview process were constructed for the data collection and reviewed by a group of experts for content and clarity before being used.

A wide variety of questions was utilized in this study. Their scope was designed specifically to answer six research questions which dealt with: a) the overall status of alcohol and drug education at each grade level, b) the extent of alcohol and drug education in regard to traffic safety, c) the types of programs and instructional methods being used in schools, d) community attitudes toward supporting alcohol and drug education programs, e) community perception of the effectiveness of existing alcohol and drug education programs, and f) future trends of alcohol and drug education in Oregon schools.

The mail-out questionnaire was the main information base for answering the research questions. A total of 19 questions was asked of 1,400 school principals in Oregon. Although 686 (49%) questionnaires were returned, 583 (42%) were found to be usable. The usable returns were from 515 public schools, eight special supported schools and 60 non-public schools.

The interview instrument had 17 questions and probed opinions from parents, teachers and students interviewed in 16 randomly selected schools. The results obtained from this questionnaire were used to support or refute the information provided by the principals. For the interview, 219 subjects were randomly selected from 16 schools. The 47 teachers and 128 students in this sample were interviewed in

person in their schools. Only a small number of the 44 parents in this sample were interviewed in that style. The majority of parents had to be interviewed during evening hours by telephone because of their work schedules.

Conclusions

The following conclusions were drawn from data provided by approximately half of all the schools in Oregon. The reader should keep in mind that proportionally, 60 percent of the junior high schools, 37 percent of the high schools, and 34 percent of the elementary schools supplied the information.

1) The overall average annual class time (hours) of teaching across all grade levels was minimal; 2.4 hours for alcohol, drugs, and traffic safety education.
2) The amount of time allotted to alcohol and drug education was almost identical at every grade level. Thus, schools are treating alcohol and drugs with equal importance sequentially in their educational curricula.
3) Most education on both alcohol and drug abuse took place between grades seven and eight, with the least amount of teaching in grades kindergarten through two, eleven and twelve.

4) Greatest emphasis for traffic safety education took place in grade ten. This coincides with the period when students in some schools are enrolled in drivers' education courses.

5) In the majority of the schools surveyed, alcohol and drug education programs were integrated with health education curriculum. An exception was in grade 12 when most of the alcohol and drug education was integrated with other subjects, viz: social sciences, physical education, science, safety education and special assemblies.

6) Health issues and provision of factual information to the students were identified as the major areas of emphasis in the existing alcohol and drug education curricula. Two content areas that received least emphasis were behavior change and alternatives to drug use.

7) Desire and need for teachers who are knowledgeable, understanding and approachable was the most frequent suggestion made by students during the personal interviews.

8) School principals cited lack of financial support and lack of teacher training as the two main obstacles in the development and implementation of alcohol and drug education programs.

9) Nearly two-thirds (63.7%) of the teachers received their training in alcohol and drug education as part of their teacher preparation. However, the nature and quality of the training they received was not examined in this study. Fourteen percent (14%) were reported to be self-trained and another 4.8 percent had no training in alcohol and drug education.

10) The types of curricula used for alcohol and drug education in Oregon schools were:

a) school developed curricula,

b) commercial curricula,

c) required competency, and

d) "others" which were not specified.

By far the largest number (73.5%) of the schools used school-developed curricula for both alcohol and drug education.

11) Most schools reported using a combination of instructional methods. However, films, lectures, and outside speakers emerged as the most favored program components in alcohol and drug education curricula in most of Oregon schools.

12) The resources which provided schools with alcohol and drug-related information also varied. However, law enforcement agencies appeared to be primary

source. Colleges and universities were ranked the lowest in providing alcohol and drug information.

13) By and large, the school principals conceded that there was strong community support for their alcohol and drug education programs. During the interviews 84 percent of parents, 78 percent of teachers and 92 percent of students thought school is the most appropriate place for alcohol and drug education.

14) Almost two-thirds (61.1%) of the school principals indicated that their schools would be willing to implement a proven effective program if one was made available and if financial support was provided. Furthermore, 13.6 percent of the principals indicated that they would be willing to implement a proven effective program even if financial support was not made available.

15) Almost 90 percent of the parents, teachers, and students interviewed felt that a significant number of students drive a car while under the influence of intoxicants and that teenage drinking was significantly contributing to traffic safety problems. More than three-quarters (84%) of them felt that traffic safety education should be combined with alcohol and drug education.

Discussion

For many years health educators have been strong advocates that the schools, both private and public, are the appropriate place for teaching young people about drugs and their effects on the individual, the family, friends, community and society at large. However, due to differing attitudes, philosophies, and values concerning use and non-use of these substances teaching about alcohol and drugs has been controversial. This lack of consensus regarding the ultimate goals and objectives of alcohol and drug education has led to the stagnation of these programs and has left them at rudimentary stages in most school districts. In view of these pronounced emotional disagreements concerning the overall goals and plans of action, teachers have, in most cases, avoided the subject. They are hesitant to introduce material which has strong possibilities of antagonizing some of the community members. This has resulted in either a total neglect of instructional programs or, at best, superficial coverage through health and social science curricula. For teachers to deal more effectively and comfortably with drug-related matters in the classroom, community consensus regarding goals and objectives of an ideal alcohol and drug education program should be reached. Teachers must also have support from all levels: state,

community, school administrators, parents and the entire school staff.

The results of this study suggest that alcohol and drug education programs in Oregon are in need of critical review. The majority of the principals who responded to this study suggested that there is a need for better cooperation and communication between schools and their communities as they work together to set goals and objectives. They feel that the programs should be planned in coordinated scope and sequence involving kindergarten through the twelfth grade. Some principals and teachers felt that the state should assist local school districts to develop curriculum that can be used throughout the state of Oregon. One of the principals who responded in this study summed it up when he said "it has been years since the State Department of Education has done anything for us in this area. With our little training in the area of drugs, it is basically our word against the kids." This statement is echoed by many school principals and teachers who felt that they could do more if they had some assistance from their school districts and the state.

The most frequent suggestions centered around the development of a well-planned comprehensive kindergarten through twelfth grade instructional program, training of teachers, and financial assistance to upgrade the existing

programs. Some principals reported that teachers were not "in tune" with current drug problems, and that some of them were using outmoded methods of instruction and materials.

Law enforcement agencies appear to be the primary sources of alcohol and drug information for the majority of schools. Some of the students interviewed, however, especially in rural areas, had anti-police attitudes. In some rural schools, students did not view law enforcement personnel as potential educators. When asked about who should be involved in the development and implementation of an alcohol and drug education program, most students in rural schools chose not to include law enforcement personnel. Conversely, and almost without exception, respondents in urban areas felt that law enforcement officials should be included in establishing the goals and objectives for alcohol and drug education programs. These findings suggest a need for police personnel in rural areas to establish closer relationships with their local schools.

The importance of training teachers to be effective alcohol and drug educators cannot be overemphasized (95, 98, 99). Alcohol and drug education deals with strongly held values and feelings and, because its ultimate goal is to change attitude and behavior, instructors need special training and skills to be able to teach effectively in this field. According to Finn and O'Gorman (1982), training

teachers to be effective alcohol educators should be designed to achieve four principal goals. The training should enable teachers to develop:

1) attitudes and values which are conducive to effective alcohol education
2) the ability to teach objectively about alcohol
3) information about alcohol use, nonuse, and abuse
4) the ability to implement effective teaching approaches and communicate effectively with students

The results of this study showed that the majority (63.7%) of the teachers received their training as part of teacher training. More than half (54%) obtained their training from workshops and 38.8 percent from inservice training. A small percentage (14%) considered themselves self-trained. Since this study did not examine the quality of education each teacher received, it is not possible to comment on the adequacy of teacher preparation and/or teachers' potential effectiveness.

In the majority of schools, alcohol and drug education programs were integrated with health education curricula. This suggests that more health teachers than teachers in other subject areas already have the knowledge and the responsibility of teaching about alcohol and drugs. If this is true in most schools, it may be appropriate in the future to establish alcohol and drug education programs within the health education curricula.

The overall average annual class time spent on alcohol and drug education across all grade levels was approximately 2.4 (hours). This value shows that very little education is actually taking place in the area of alcohol and drugs.

There is reason to believe that not all the principals who responded gave correct information. For example, two of the school principals gave their alcohol and drug education programs high ratings when they filled out their questionnaires. However, during the on-site interview, teachers and students gave difference responses. In one of the two schools, students and teachers reported that except for casual coverage in a health class, there was no alcohol and drug education program. When the principal was interviewed by this researcher, he stated that the school policy was to crack down on any students who got involved with drugs. This principal went on to say that this type of approach was effective in reducing drug-related problems in their school, especially if the local law enforcement was supportive. In the second school whose principal had given a high rating to their drug education program, the health education teachers who were charged with teaching about alcohol and drugs complained of lack of administrative support and lack of trained teachers. One of the h lth education teachers in this school reported that drug abuse was definitely widespread but he didn't feel qualified to handle the topic in a

classroom situation. In one of the schools whose principal had given a medium rating to the effectiveness of their alcohol and drug education program, two health education teachers (who according to the school principal were charged with teaching about alcohol and drugs) were totally against drug education in schools. During the interview, both teachers said that students had enough information about drugs and that adults should leave them alone.

Some principals indicated that they only provide alcohol and/or drug education lectures if any drug incidents come to their attention. Others suggested that time allotted for alcohol and drug education should be standardized at each grade level and methods determined so that each teacher can verify the teaching block's time. They felt that a specified amount of time per year needs to be set aside for alcohol and drug education. Some of the respondents in this study stated that "we cannot just 'add' it to or 'include' it in other subject areas." They felt strongly that alcohol and drug education programs must have their own priority and place within school curricula like the "3Rs."

Most education on both alcohol and drug abuse in schools surveyed took place between grades five and eight, with the least amount of teaching in grades 11 and 12. It is particularly surprising that many schools appeared to

stop teaching about alcohol and drugs after grade ten since that is the time when most students begin to drive.

The highest overall average annual hours of traffic safety education was at grade ten (Figure 4a). However, the average annual hours were much lower (three hours) for alcohol and drug education than for traffic safety. This trend continued until the time when most students received their driver's license. Since this is the period when most students are spending more time with peers and are more exposed to opportunities for drinking, drug use and driving, it would seem logical to intensify the drug education at these grade levels. Almost half (47%) of all the subjects interviewed for this study felt that the existing programs have had no impact on teenage drinking and driving. Furthermore, 89 percent of them felt that teenage drinking is significantly contributing to traffic safety problems. The increased vulnerability of this population category has also been documented by the national statistics which show marked increase in alcohol, drug abuse related traffic offenses for this age group. A similar report produced by Western Insurance Information Service in the fall of 1982 stated that the most dangerous and deadly drivers are the 18-year olds. The report goes on to say that this group kills themselves, their passengers, other drivers,

pedestrians, and other innocent victims at the rate of two and one-half times greater than other drivers.

The types of curricula used for alcohol and drug education in Oregon schools include school-developed curriculum, commercial curriculum, required competency and "others" which were not specified by the principals. By far, the majority of schools used school-developed curricula for both alcohol and drug education. The scope of this study did not include an evaluation of the quality of each of these programs. There undoubtedly are some ongoing school-developed programs that are sound and effective. Many more school programs probably exist where concerted efforts are being made to discover program weaknesses and to cope with conditions that need upgrading. At the same time, there is reason to believe that there are some schools in which alcohol and drug education is virtually non-existent or where prevailing practices can be legitimately challenged. For example, some of the principals who responded gave high ratings to their programs. However, when parents and students of these schools were intereviewed they reported that their alcohol and drug education programs were ineffective and, in some cases, non-existent.

Most schools reported using a combination of instructional methods. However, films and lectures dominated as methods of choice in nearly 90 percent of the schools. Over

85 percent of the schools in Oregon used films for reasons not easily identified. However, several teachers reported that they do not feel comfortable teaching about drugs and some felt that their students knew more about drugs, or at least had a larger drug vocabulary than they did. The fact that students could pose questions using unfamiliar drug terminology put many teachers in awkward positions, revealing their ignorance about drugs. Sheppard and Goodstadt (1979) have stated that for many teachers, films are frequently thought to be the solution to this dilemma and that a 30 minute drug-education film could be used to fill the class period and still transmit much needed information. However, there are problems with this as some of the students interviewed in this study reported that the films were either too old, one-sided and/or propaganda type. This raises the question of effectiveness.

At a time when financial considerations weigh heavily on many communities and school systems face constant budget cutbacks, it becomes very difficult for a classroom teacher to get new acceptable films from the distributors. Sheppard and Goodstadt (1979) summarized the film-related problems faced by classroom teachers when they stated that:

> . . . teachers do not use films because they are difficult to obtain; the films teachers use are old and frequently out-dated; students do not give good ratings to films they see; 54 percent rated the films they had seen as "fair-to-good"; teachers tend not to use drug education films; libraries and school boards do not

> purchase drug education films as they get few requests for them (p. 373).

When used as a source of supplemental information rather than as the entire program, updated films can have an important place in a drug education program. Drug education films can be effective tools to start discussion, deliver drug-related information in an interesting manner, validate and confirm what students and teachers have discussed, and can also be used to clear up misinformation and misconceptions. If such films are to be a part of a total alcohol and drug education program, the youth models must be invited to take part in their development and production. They are the ones who understand the dilemma faced by their peers, and they are the ones who understand how to communicate better with other youth. An example of this, a new film called "Just Along for the Ride," has just won the Gold Camera Award (first Place) in the U.S. Industrial Film Festival. The film was produced by the National Association of Independent Insurers (NAII) and concerns peer pressure, drinking and driving. It also demonstrates effectively the results when young people mix drinking and driving. The NAII has shown this film to a group of governmental officials, Congressional staffers, educators, law enforcement and insurance executives. The film was enthusiastically received. The Washington Post reports that the "Just Along for the Ride" film was written, "not by adults but by young

people, with their feelings, their antics, and their jargon; it is the kind of film that makes others think before drinking and driving."

The subjects responding to this study felt that drug education films should deal with such factors as peer pressure, how and why some young people get in trouble with drugs, coping, decision-making skills, driving under the influence and traffic safety, misinformation, misconception and alternatives to drug use.

Except for the category of provision of factual information, parents, teachers and students differed significantly in what they felt were the ideal objectives of alcohol and drug education programs. A large number of teachers and students did not feel that attitude change and behavior change would be among the ideal objectives in alcohol and drug education programs. This may be partially explained by the fact that some students viewed behavior change as a form of control in which adults attempt to impose their own beliefs and values on them. Some teachers may be aware of this perception and that could explain why their results were almost identical to those of students. On the other hand, at least 77 percent of parents reported that attitude and behavior change should be among the ideal objectives of alcohol and drug education programs.

While the principals generally felt that existing programs were effective, they conceded that teachers were not necessarily seen as the most reliable sources of alcohol and drug information by students. The principals felt students view their peers as the most reliable sources of drug-related information. This is documented by nearly nine out of ten people interviewed in this study who felt that peers, more than any other group, strongly influence students' drug use. This peer influence could be used as an educational tool. Some researchers have suggested that since "rapping" seems to be a popular pastime activity for most older students, use of "rap" sessions may be very worthwhile in getting drug-related information across to this age group (grades 10 through 12).

A number of respondents felt that in order to reduce the level of peer influence and misinformation, there is a need to educate teachers and parents in the area of alcohol and drug abuse.

Although teachers had different suggestions about teacher training, the majority of them conceded that teacher training should be developed to include: a) more time for teacher preparation; b) release time for teachers to enable them to attend workshops and/or take summer courses relating to drug education; c) increase time dealing with attitudes,

teaching techniques and information about alcohol and drug abuse.

Teachers could benefit from an organized statewide alcohol and drug education teacher workshop(s) or inservice program(s) that would provide teachers with necessary and accurate drug-related information. The Oregon State Department of Education and/or other institutional agencies like the Oregon Health Education Service (OHES) at the University of Oregon could plan and carry out these workshops.

Teachers with the responsibility of teaching about alcohol and drugs, at all grade levels, should have the opportunity to attend these workshops wherever they would be held. The workshops should enable teachers to: a) learn how to teach about alcohol and drugs effectively and without getting trapped in confusion and controversies relating to alcohol and drug abuse, b) learn to upgrade their existing programs, c) identify and select the new comprehensive programs that appear to be effective, and d) share and update their drug-related information and knowledge.

A number of teachers and principals responding to this study, especially those in rural areas, reported that they felt intimidated when some of their students posed questions that involved drug terms they were not familiar with. These respondents expressed a desire for monthly publications,

such as newsletters or pamphlets that could provide teachers with the latest drug-related information. These publications could be compiled and be made available to every school monthly and/or upon request. Since there is a unique vocabulary specific to the young drug culture, these types of resources -- if they include street terminology -- could be lifesavers for most teachers who have limited training. Some teachers also expressed a desire for instructional units (cookbook-type teaching guide) written specifically for alcohol and drug education teachers.

A small percentage of teachers and students interviewed for this study felt that it is important for the schools to bring in rehabilitated former drug users. They felt that students need to have more contact with people whose lives have been seriously affected by alcohol and drugs. Researchers have reported that these individuals have high credibility provided they do not glamorize their drug experiences.

A number of students interviewed for this study complained that their textbooks were outdated, boring, and often dwelling on negative rather than positive lifestyles and alternatives to drug use. The students felt that a good textbook should be simple and attractive to read, have a lot of pictures and/or comics, and should not necessarily dwell on the negatives. Almost without exception, respondents

felt that "peer pressure" was a realistic threat to young people of all ages, and that this should be taken into consideration in developing good textbook and/or films for each grade level.

The majority of the adults interviewed for this study were in favor of parent education. However, some of the students insisted adamantly that only a small percentage of parents would ever be objective or open enough to be able to understand and assist their children in cases of drug-related problems. Parents were described by some students as quite naive and unaware of children's involvement in drug activities. Students interviewed felt that both parents and children need the right information in order to communicate openly. This communication discrepancy illustrates the need for efforts to educate both adults and children and to provide them with accurate information and problem-solving techniques.

A number of the parents interviewed felt that they had no way of knowing if their children were involved in drugs and they certainly did not want to wait until it was too late. Some parents felt that it would be helpful to have a parent information publication with a list of signs that indicate drug involvement. For example, children who are involved in drug activities may:

a) suddenly change friends

b) become less involved with family activities

c) start telling untrue stories about where they have been or what they have been doing

d) want to be left alone

e) become explosive if a family member enters his/her room

Other signs include: name calling, mood swings, drop in grades and/or dislike of school, rebelliousness, and disappearance of money from piggy banks, purses, and wallets. Compiling information of this type and making it available may help parents to intervene and/or get necessary help at an early stage of the problem and before it is too late.

Some subjects interviewed for this study felt that the "macho" image on television should be replaced by an appropriate role model. Their suggestion was that televised programs aimed at de-glamorizing the "macho" image on television should be presented at regular intervals. There were respondents also who felt that communities should be encouraged to create after-school activities that might help to give students alternatives to drug use. These recreational activities may include sports, trips, community projects, and vocational education. A large number of students and a small number of teachers interviewed for this study felt that most kids are getting involved with drugs because of peer pressure and/or because there is "nothing

better to do." The fact that school principals conceded that alternatives to drug use received little emphasis in their school curriculum further demonstrates the urgent needs of these programs.

Based on the data provided by approximately half of the Oregon schools, the findings of this study suggest that there is strong support for alcohol and drug education in Oregon schools. Almost nine in ten (88%) of the subjects interviewed for this study thought the school would be the most appropriate place for alcohol and drug education. Furthermore, most of them were also in support of alcohol and drug education starting at elementary levels. More parents (27%) than teachers (17%) and students (1.6%) were in favor of alcohol and drug education starting in kindergarten.

The Review of the Literature for Chapter II revealed that alcohol and drug education programs are now starting to emerge in several school districts in Oregon. However, the review of the literature indicated that little attempt has been made to evaluate the effectiveness of these programs. As teachers, administrators and community educators become more aware of the drug-related problems in their areas, they will need to know more about the effectiveness of these programs.

Recommendations

This study was designed to establish baseline data regarding the status of alcohol and drug education in Oregon schools. The extent of inclusion of traffic safety education in alcohol and drug education was also assessed. The data were provided by approximately half of all Oregon schools. Proportionately, 60 percent of junior high schools, 37 percent of the high schools, and 34 percent of the elementary schools participated. In view of the findings, the following recommendations are proposed:

1. A. Each local school district should strive to provide an alcohol and drug education program which:

   (1) is comprehensive and appropriate for kindergarten through grade 12.

   (2) is student-oriented and meets students' needs as identified by students, school personnel, and community members

   (3) has essential accurate up-to-date alcohol and drug information

   (4) includes attitudes, behaviors, and decision-making skills

   (5) promotes positive self-concept and self-esteem

   (6) prepares the students to be able to handle peer pressure

   (7) deals with driving under the influence and traffic safety. A need to intensify the alcohol and drug education after grade ten is indicated.

   (8) deals with health aspects of alcohol and drug abuse.

(9) promotes alternatives to alcohol and drug abuse

B. Each local school district should plan and carry out self-evaluation studies of their alcohol and drug education programs to determine existing strengths and weaknesses. Some facets of the program that should be examined are:

(1) Teacher preparation in alcohol and drug education and teaching effectiveness of staff already assigned to alcohol and drug instruction.

(2) Inservice opportunities available to teachers for strengthening and expanding their competencies in alcohol and drug education.

(3) Scheduling practices and time allotments for alcohol and drug instruction.

(4) Organizational patterns and administrative factors affecting development and implementation of alcohol and drug education programs. Since administrative support is the key to a successful program, it is recommended that all principals and superintendents be required to attend a refresher course or workshop for alcohol and drug education.

(5) Teaching resources, viz: textbooks, films, publications and local volunteers to be contacted by teachers.

(6) Parent education programs in alcohol and drug abuse to assure reinforcement of what is learned in schools.

(7) After school recreational activities to give students alternatives to drug use.

2. The State Department of Education should:

(1) Conduct an evaluative study to determine the effectiveness of the existing programs and identify at least one that can be implemented throughout the state by those schools which need a program.

(2) Evaluate availability of financial resources that would enable schools to upgrade their existing alcohol and drug education programs or develop and implement new ones.

(3) Examine teacher preparation in alcohol and drug education and possibly develop guidelines in terms of time and depth of content.

(4) Plan and carry out workshops or inservices throughout the state to enable teachers to strengthen and expand their knowledge in alcohol and drug education.

(5) Provide local school districts with a list of specialist speakers in alcohol and drug education. However, these speakers should not replace regular classroom teachers.

3. Provisions be made to allow for longitudinal research that would determine the eventual impact of the above efforts on students' drinking, knowledge, behavior and attitudes about alcohol and drugs.

APPENDIX A

TRAINING SOURCES FOR ALCOHOL AND DRUG EDUCATION TEACHERS

APPENDIX A

Training Sources for Alcohol and Drug Education Teachers*

		Number of Schools Utilizing Each Source	Percentage
1.	Part of teacher preparation	347	63.7
2.	Workshop	294	54.0
3.	Inservice	217	39.8
4.	Special coursework	151	27.7
5.	On their own	76	14.0
6.	Unknown	71	13.0
7.	No training	26	4.8

*Corresponds with Figure 1

APPENDIX B

ALCOHOL EDUCATION BY GRADE LEVEL

APPENDIX B

Alcohol Education by Grade Level*

Grade Level	Number of Schools	Teaching Required	Teaching Taking Place/ Not Required	No Teaching Taking Place
K-2	280	29 (10.4%)	110 (39.3%)	141 (50.4%)
3-4	319	58 (18.2%)	182 (57.1%)	79 (24.8%)
5	340	111 (32.6%)	189 (55.6%)	40 (11.8%)
6	333	140 (42.0%)	167 (50.2%)	26 (7.8%)
7	247	145 (58.7%)	91 (36.8%)	11 (4.5%)
8	239	132 (55.2%)	94 (39.3%)	13 (5.4%)
9	147	82 (55.8%)	45 (30.6%)	20 (13.6%)
10	153	93 (60.8%)	49 (32.0%)	11 (7.2%)
11	107	42 (39.3%)	47 (43.9%)	18 (16.8%)
12	97	35 (36.1%)	37 (38.1%)	25 (25.8%)

* Corresponds with Figure 2a

APPENDIX C

DRUG EDUCATION BY GRADE LEVEL

APPENDIX C

Drug Education by Grade Level*

Grade Level	Number of Schools	Teaching Required	Teaching Taking Place/ Not Required	No Teaching Taking Place
K-2	280	36 (12.9%)	108 (38.6%)	136 (48.6%)
3-4	319	61 (19.1%	171 (53.6%)	87 (27.3%)
5	340	106 (31.2%)	178 (52.4%)	56 (16.5%)
6	333	133 (39.9%)	160 (48.1%)	40 (12.0%)
7	247	132 (53.4%)	86 (34.8%)	29 (11.8%)
8	239	125 (52.3%)	87 (36.4%)	27 (11.3%)
9	147	77 (52.4%)	44 (29.9%)	26 (17.7%)
10	153	87 (56.9%)	46 (30.1%)	20 (13.1%)
11	107	40 (37.4%)	45 (42.0%)	22 (20.6%)
12	97	33 (34.0%)	37 (38.2%)	27 (27.8%)

* Corresponds with Figure 2b

APPENDIX D

PERCENTAGE OF SCHOOLS COMBINING ALCOHOL AND DRUG EDUCATION WITH THE LISTED SUBJECTS AT EACH GRADE LEVEL

APPENDIX D

Percentage of Schools Combining Alcohol and Drug Education with the Listed Subjects at Each Grade Level*

Grade Level	Number of Schools	Special Assemblies, P.E., Sciences and Safety	Health	Independently Taught
K-2	147	10.5	75.3	14.3
3-4	205	9.6	74.3	16.1
5	248	10.1	69.8	20.1
6	250	11.3	65.1	23.6
7	183	17.7	59.8	22.5
8	177	17.2	58.3	24.5
9	103	20.9	58.1	21.0
10	119	20.7	47.2	23.1
11	74	32.0	52.4	15.6
12	53	57.5	25.5	17.0

* Corresponds with Figure 3

APPENDIX E

THE OVERALL AVERAGE ANNUAL HOURS OF ALCOHOL AND DRUG EDUCATION TAUGHT AT EACH GRADE LEVEL

APPENDIX E

The Overall Average Annual Hours of Alcohol and Drug Education Taught at Each Grade Level*

Grade Level	Number of Schools	Alcohol	Drugs	Traffic Safety
K-2	280	0.94	1.0	3.30
3-4	319	1.74	1.72	3.20
5	340	3.20	3.20	3.10
6	333	3.50	3.50	2.30
7	247	3.90	3.90	1.60
8	239	3.70	3.80	1.50
9	147	2.50	2.50	2.10
10	153	2.60	2.70	5.70
11	107	1.40	1.40	1.00
12	97	0.89	0.83	0.70

* Corresponds with Figure 4a

APPENDIX F

AVERAGE ANNUAL CLASS HOURS OF ALCOHOL AND DRUG EDUCATION REPORTED AT EACH GRADE LEVEL

APPENDIX F

Average Annual Class Hours of Alcohol and Drug Education Reported at Each Grade Level*

Grade Level	Number of Schools	Alcohol	Drugs	Traffic Safety
K-2	73	5.6	5.3	7.9
3-4	126	6.0	5.8	7.4
5	183	7.6	7.4	7.0
6	197	7.7	7.8	5.9
7	162	10.4	10.7	6.5
8	150	10.8	10.3	6.6
9	95	11.6	12.3	14.5
10	82	11.0	11.4	20.4
11	56	10.8	11.2	10.9
12	42	9.1	9.1	9.1

* Corresponds with Figure 4b

(Those schools that failed to give a specific amount of time in their responses are excluded from these figures.)

APPENDIX G

TYPES OF ALCOHOL AND DRUG EDUCATION CURRICULUM BEING USED IN SCHOOLS

APPENDIX G

Types of Alcohol and Drug Education Curriculum Being Used in Schools*

Types of Curriculum	Total Number of Schools that Responded	Number of Schools Using the Curriculum	Percentage
1. School-Devloped Curriculum			
ALCOHOL	529	389	73.5
DRUGS	524	387	73.9
2. Commercial Curriculum			
ALCOHOL	529	101	19.1
DRUGS	524	94	17.9
3. Other Curriculum			
ALCOHOL	529	96	18.2
DRUGS	524	90	17.2
4. Required Competency			
ALCOHOL	529	76	14.4
DRUGS	524	76	14.5

* Corresponds with Figure 5

APPENDIX H

INSTRUCTIONAL METHODS UTILIZED IN SCHOOLS FOR ALCOHOL AND DRUG EDUCATION

Instructional Methods Utilized in Schools for Alcohol and Drug Education*

Methods of Curriculum		Number of Schools that Responded	Number of Schools Using Each Method	Percentage
Films	ALCOHOL	560	494	88.2
	DRUGS	558	476	85.3
Lecture	ALCOHOL	560	490	87.5
	DRUGS	558	487	87.3
Speakers	ALCOHOL	560	401	71.6
	DRUGS	558	398	71.3
Group Projects	ALCOHOL	560	312	55.7
	DRUGS	558	313	56.1
Commercial Material	ALCOHOL	560	275	49.1
	DRUGS	558	267	47.9
Role Playing	ALCOHOL	560	155	27.1
	DRUGS	558	152	27.2
Other Methods	ALCOHOL	560	46	8.2
	DRUGS	558	40	7.2

* Corresponds with Figure 6

APPENDIX I

RESOURCE PERSONNEL THAT PROVIDE OREGON SCHOOLS WITH ALCOHOL AND DRUG INFORMATION

Resource Personnel that Provide Oregon Schools with Alcohol and Drug Information*

Sources	Total Number of Schools that Responded	Number of Schools Obtaining Information from a Particular Source	Percentage
Law Enforcement			
ALCOHOL	534	402	75.3
DRUGS	529	409	77.3
Counselors			
ALCOHOL	534	236	44.2
DRUGS	529	232	43.9
Treatment Programs			
ALCOHOL	534	192	36.0
DRUGS	529	181	34.2
Other Resources			
ALCOHOL	534	171	32.0
DRUGS	529	152	28.7
Traffic Safety Groups			
ALCOHOL	534	126	23.6
DRUGS	529	108	20.4
College/University Personnel			
ALCOHOL	534	68	12.7
DRUGS	529	66	12.5

* Corresponds with Figure 7a

APPENDIX J

CONDITIONS UNDER WHICH SCHOOLS WOULD BE WILLING TO IMPLEMENT A PROVEN EFFECTIVE PROGRAM IF ONE WAS MADE AVAILABLE

Conditions under Which Schools Would Be Willing to Implement a Proven Effective Program If One Was Made Available*

Sources	Total Number of Schools that Responded	Number of Willing Schools	Percentage
1. At no cost to their school district	537	220	50.0
2. At some cost to their school district	537	328	61.1
3. At full cost to their school district	537	73	13.6

* Corresponds with Figure 11

APPENDIX K

TRANSMITTAL LETTERS AND MAIL-QUESTIONNAIRE

VERNE A DUNCAN
State Superintendent
of Public Instruction

OREGON DEPARTMENT OF EDUCATION
700 PRINGLE PARKWAY SE, SALEM, OREGON 97310 PHONE (503) 378-3569

April 7, 1983

TO: All Oregon Public School Principals

RE: Study to Ascertain the Status of Alcohol and Drug Education in Oregon Public Schools

I am pleased to announce that the Oregon Department of Education is funding a study to ascertain the status of alcohol and drug education in Oregon public schools. We are especially interested in gathering information that relates to teenage drinking and driving, as this situation is the number one killer of people 15-24 years of age.

The study is being conducted by Gabriel Maritim, a doctoral candidate at the University of Oregon. During April he will be sending you a questionnaire and asking a few of you for a personal interview.

Thank you for cooperating in this valuable study.

Verne A. Duncan
State Superintendent
of Public Instruction

jh
cc: District Superintendent

VERNE A DUNCAN
State Superintendent
of Public Instruction

OREGON DEPARTMENT OF EDUCATION
700 PRINGLE PARKWAY SE, SALEM, OREGON 97310 PHONE (503) 378-3569

April 19, 1983

TO: Principal

RE: Status of Alcohol and Drug Education in Oregon Schools

My name is Gabriel Maritim. I am a doctoral student at the University of Oregon. I believe you have already received a letter from Verne Duncan referring to the study.

Under the auspices of the Department of Education, I am conducting a study to determine the status of alcohol and drug education in Oregon schools. This is funded through a grant from the Oregon Traffic Safety Commission (Section 402, National Highway Traffic Safety Administration funds). Special emphasis is being placed on alcohol and drugs as they relate to traffic safety.

The results of this study will be used to determine baseline data and to provide background information for some further evaluation of specific curricula. Identification and implementation of new curricula could be supported through additional 402 funding.

The enclosed questionnaire should be answered by the principal although he or she may wish to consult with those instructors given the responsibility of teaching about alcohol and/or drugs. It would be appreciated if you will complete the questionnaire and return it to me prior to May 9, 1983. Other phases of this research cannot be carried out until we receive those questionnaires. Based on the information we obtain from these questionnaires, we plan to conduct interviews in a few selected schools in different parts of Oregon. It is imperative that we be able to conduct these interviews before the schools are closed for the summer. We would welcome any comments that you may have concerning any aspect of alcohol and drug education not covered by the questionnaire.

I realize that as a principal you are very busy. Therefore, I would like to thank you in advance for the time you spend in filling out the attached questionnaire. We hope this study will provide some information that will be useful in combating the problem of drug abuse in Oregon.

If you would like a summary of this study, please print your name and address in the space provided at the lower left hand corner of the enclosed questionnaire.

Sincerely,

Gabriel K. Maritim

Len Tristch
Specialist
Health Education

ht
Enclosure

No._____

STATUS OF ALCOHOL AND DRUG EDUCATION IN OREGON SCHOOLS

DIRECTIONS

Some of the questions you are about to answer have continuum lines. The left end of each line represents a "very positive" response whereas the right end represents a "very negative" response. Please circle the number (value) above the line that most closely corresponds to your response to each question.

In those cases where none of the options appropriately represent your answer, please feel free to write your own response after the word "Other___". There are NO RIGHT OR WRONG answers. If you have no information about a question, please mark the "Unknown" response. As for the open-ended questions, your additional comments or suggestions will be highly appreciated.

EXAMPLE 1 VERY POSITIVE RESPONSE

Students consider drug education to be:

Very Important (5) 4 3 2 1 Very Unimportant

EXAMPLE 2 VERY NEGATIVE RESPONSE

Students consider drug education to be:

Very Important 5 4 3 2 (1) Very Unimportant

EXAMPLE 3 NEUTRAL RESPONSE

Students consider drug education to be:

Very Important 5 4 (3) 2 1 Very Unimportant

I. 1. Please indicate the following:

a) Number of students in your school_____

b) Total number of teachers in your school_____

c) Number of teachers involved in alcohol and drug education_____

2. Where do your alcohol and drug education teachers get training?
(Mark "x" in the appropriate space(s).)

___Part of teacher preparation ___Workshops

___Special coursework ___Unknown

___Inservice ___None

Other: please specify _____

_____

_____

3. Some schools use commercial curriculums whereas others develop their own locally.

a) Please indicate the name (if any) and the source(s) of your curriculum.

_____

_____

b) How was it selected or developed

_____

_____

4. Does your alcohol and drug education program deal with traffic safety in relation to drinking and driving?_____

If no, please indicate the subject area in which traffic safety education is integrated with

_____

_____

II. 5. In the space provided below, indicate the status of alcohol and drug education at each grade.
Please mark as follows: O - No teaching taking place
X - Teaching taking place but not required
* - Teaching taking place and required

Grade Level	K-2	3-4	5	6	7	8	9	10	11	12
Alcohol										
Drugs										

6. Some schools combine alcohol and/or drug education with other subject areas. If this is the case in your school, please indicate the subjects it is integrated with in each grade. Put down "I" if taught independently.

Grade Level	K	1	2	3	4	5	6
Alcohol							
Drugs							
		7	8	9	10	11	12
Alcohol							
Drugs							

7. In the space(s) provided below, please put down an "X" to indicate the status of your alcohol and/or drug education curriculum.

Status	School Developed Curriculum	Required Competency	Commercial Curriculum (Name)	Other (Specify)
Alcohol				
Drugs				

8. Please put an "X" in the space(s) provided below to indicate the method(s) of instruction used in your school.

Method of Instruction	Lecture	Group Work (Projects)	Role Playing	Films	Speakers	Commercial Material	Other (Specify)
Alcohol							
Drugs							

9. Please indicate the amount of class time per year each of the listed topics below is taught in each grade level.

Grade Level	K-2	3-4	5	6	7	8	9	10	11	12
Alcohol										
Drugs										
Traffic Safety										

10. Please indicate the resource personnel that provide you with alcohol and drug information by placing an "X" in the appropriate space(s).

Resource Personnel	Law Enforcement	Traffic Safety Groups	Counselors	Treatment Programs	College/ University Personnel	Other (Specify)
Alcohol						
Drugs						

III. 11. How would you rate your community in the following areas:

a) Support for your school High 5 4 3 2 1 Low Unknown___
b) Concern for alcohol abuse High 5 4 3 2 1 Low Unknown___
c) Concern for drug abuse High 5 4 3 2 1 Low Unknown___
d) Concern for youth delinquency High 5 4 3 2 1 Low Unknown___
e) Drunk driving and traffic safety High 5 4 3 2 1 Low Unknown___

12. Indicate the degree of emphasis placed on the following aspects of your alcohol and drug education program.

a) Knowledge Conceptualization:
Alcohol Extensive 5 4 3 2 1 Nonexistent Unknown___
Drugs Extensive 5 4 3 2 1 Nonexistent Unknown___

b) Factual Information:
Alcohol Extensive 5 4 3 2 1 Nonexistent Unknown___
Drugs Extensive 5 4 3 2 1 Nonexistent Unknown___

c) Attitude Change:
Alcohol Extensive 5 4 3 2 1 Nonexistent Unknown___
Drugs Extensive 5 4 3 2 1 Nonexistent Unknown___

d) Behavior Changing:
Alcohol Extensive 5 4 3 2 1 Nonexistent Unknown___
Drugs Extensive 5 4 3 2 1 Nonexistent Unknown___

e) Social Issues:
Alcohol Extensive 5 4 3 2 1 Nonexistent Unknown___
Drugs Extensive 5 4 3 2 1 Nonexistent Unknown___

f) Health Issues:
Alcohol Extensive 5 4 3 2 1 Nonexistent Unknown___
Drugs Extensive 5 4 3 2 1 Nonexistent Unknown___

g) Alternatives to drug use:
Extensive 5 4 3 2 1 Nonexistent Unknown___

h) Other: please specify_____

13. As it relates to traffic safety, indicate the degree of emphasis placed on each of the following areas when teaching about alcohol and drug abuse.

a) Legal Aspects:
Alcohol Extensive 5 4 3 2 1 Nonexistent Unknown___
Drugs Extensive 5 4 3 2 1 Nonexistent Unknown___

b) Pharmacological Aspects:
Alcohol Extensive 5 4 3 2 1 Nonexistent Unknown___
Drugs Extensive 5 4 3 2 1 Nonexistant Unknown___

c) Driving Behavior and Accident Potential:
Alcohol Extensive 5 4 3 2 1 Nonexistent Unknown___
Drugs Extensive 5 4 3 2 1 Nonexistent Unknown___

d) Other: please specify_____

14. a) Indicate how you think the following people will rate:

(I) The **IMPORTANCE** of having an alcohol and drug education in your school.
(II) The **EFFECTIVENESS** of your existing alcohol and drug education programs.

PERSONS	(I) IMPORTANCE	(II) EFFECTIVENESS
Yourself		
Alcohol	___Unknown High 5 4 3 2 1 Low	High 5 4 3 2 1 Low Unknown___
Drugs	___Unknown High 5 4 3 2 1 Low	High 5 4 3 2 1 Low Unknown___
Teachers		
Alcohol	___Unknown High 5 4 3 2 1 Low	High 5 4 3 2 1 Low Unknown___
Drugs	___Unknown High 5 4 3 2 1 Low	High 5 4 3 2 1 Low Unknown___
Students		
Alcohol	___Unknown High 5 4 3 2 1 Low	High 5 4 3 2 1 Low Unknown___
Drugs	___Unknown High 5 4 3 2 1 Low	High 5 4 3 2 1 Low Unknown___
Parents		
Alcohol	___Unknown High 5 4 3 2 1 Low	High 5 4 3 2 1 Low Unknown___
Drugs	___Unknown High 5 4 3 2 1 Low	High 5 4 3 2 1 Low Unknown___
Non-School Professionals		
Alcohol	___Unknown High 5 4 3 2 1 Low	High 5 4 3 2 1 Low Unknown___
Drugs	___Unknown High 5 4 3 2 1 Low	High 5 4 3 2 1 Low Unknown___
Community		
Alcohol	___Unknown High 5 4 3 2 1 Low	High 5 4 3 2 1 Low Unknown___
Drugs	___Unknown High 5 4 3 2 1 Low	High 5 4 3 2 1 Low Unknown___

b) In your opinion, what constitutes effectiveness?_____

15. To what extent have the following facets promoted or hindered your alcohol and drug education program in terms of development, improvement, practices or provisions?

a) Administrative Support:
Alcohol Promoted 5 4 3 2 1 Hindered Unknown___
Drugs Promoted 5 4 3 2 1 Hindered Unknown___

b) Financial Support:
Alcohol Promoted 5 4 3 2 1 Hindered Unknown___
Drugs Promoted 5 4 3 2 1 Hindered Unknown___

c) Qualified Instructors:
Alcohol Promoted 5 4 3 2 1 Hindered Unknown___
Drugs Promoted 5 4 3 2 1 Hindered Unknown___

d) Availability of Resources:
Alcohol Promoted 5 4 3 2 1 Hindered Unknown___
Drugs Promoted 5 4 3 2 1 Hindered Unknown___

e) Community Support:
Alcohol Promoted 5 4 3 2 1 Hindered Unknown___
Drugs Promoted 5 4 3 2 1 Hindered Unknown___

f) Other: please specify_____

16. In your opinion, to what degree do you think the students view the following people as the best sources of alcohol and drug information ("High" represents the best and "Low" represents the worst).

a) School (Teachers and Counselors):
Alcohol High 5 4 3 2 1 Low Unknown___
Drugs High 5 4 3 2 1 Low Unknown___

b) Parents:
Alcohol High 5 4 3 2 1 Low Unknown___
Drugs High 5 4 3 2 1 Low Unknown___

c) Peers:
Alcohol High 5 4 3 2 1 Low Unknown___
Drugs High 5 4 3 2 1 Low Unknown___

d) Law Enforcement Officials:
Alcohol High 5 4 3 2 1 Low Unknown___
Drugs High 5 4 3 2 1 Low Unknown___

e) Clients of Rehabilitation Programs:
Alcohol High 5 4 3 2 1 Low Unknown___
Drugs High 5 4 3 2 1 Low Unknown___

f) Other: please specify_____

_____

IV. 17. In your opinion, what needs to happen in order for your current alcohol and drug education program to be more effective?_____

_____

_____

_____

18. In your opinion, if a proven effective alcohol and drug education program was made available, would the school board and the administration of your district be willing to implement it? (Please put and "X" to indicate your response.)

___a) At no cost to your district
___b) At some cost to your district
___c) At full cost to your district

V. 19. These last three questions are to be answered by the principals of those schools that do NOT have a specified alcohol and/or drug education program.

a) Why do you not have a program?_____

_____

_____

_____

b) Did you have one before? If so, state the reason(s) why you no longer have it.

_____

_____

_____

_____

c) What needs to happen in your school in order to implement one?

_____
_____
_____
_____
_____

If you would like us to send you a summary of the study results please print your name and address in the space provided below:

Name_____
Address_____
_____

Please return the completed questionnaire to:
Gabriel Maritim
Oregon Department of Education
700 Tringle Parkway S.E.
Salem, Oregon 97310

APPENDIX L

INTERVIEW QUESTIONNAIRE

INTERVIEW QUESTIONNAIRE

RESPONDENT _____ _____ _____ _____

SCHOOL # _____

1. In your opinion, do you think that there is an alcohol and/or drug abuse problem in your school(s)?
   a) _____ No
   b) _____ Yes
   Extensive 5 4 3 2 1 Nonexistent

2. In your opinion, who most strongly influences the students to use or not to use drugs?
   a) _____ Parents
   b) _____ Peers
   c) _____ Others _____

3. What would you say is the most commonly abused drug in your school at this time?
   a) _____ Alcohol
   b) _____ Marijuana
   c) _____ Cocaine
   d) _____ Others _____

4. Please rank the following three social problems in order of importance from the most important to the least important: crime in streets, drug abuse, and driving under the influence of incoxicants (DUII).
   a) _____ Crime, drug abuse, DUII
   b) _____ Crime, DUII, drug abuse
   c) _____ Drug abuse, crime, DUII
   d) _____ Drug abuse, DUII, crime
   e) _____ DUII, drug abuse, crime
   f) _____ DUII, crime, drug abuse

5. Do you think there are a lot of students who drive a car while under the influence of alcohol and/or other drugs?
   a) _____ No
   b) _____ Yes
   Extensive 5 4 3 2 1 Nonexistent

6. Do you think that teenage drinking is significantly contributing to traffic safety problems?
   a) _____ No
   b) _____ Yes
   Extensive 5 4 3 2 1 Nonexistent

7. Does your school(s) have an alcohol and/or drug education program?
   a) _____ No
   b) _____ Yes

8. In your opinion, has the program been effective?
   a) _____ No
      Why not?_____
      _____
   b) _____ Yes
      Effective 5 4 3 2 1 Ineffective
      Explain how you view "effectiveness"_____
      _____
      _____

9. What should be the objectives in an alcohol and drug education program?
   a) _____ Provide factual information
   b) _____ Attitude change
   c) _____ Behavior change
   d) _____ Coping and decision-making skills
   e) _____ Health issues
   f) _____ Driving under the influence and traffic safety
   g) _____ Others_____
      _____

10. In terms of developing a good alcohol and drug education program, who should be involved?
   a) _____ School (teachers, counselors, and administrators)
   b) _____ Parents
   c) _____ Students
   d) _____ Law enforcement personnel
   e) _____ Personnel from drug treatment facilities
   f) _____ Others_____
      _____

11. Do you think school is the most appropriate place for an alcohol and drug abuse education program?
   a) _____ Yes
      Why?_____
      _____
   b) _____ No
      If not, where would the most appropriate place be?_____
      _____

12. If school is the most appropriate place, at what grade level should it begin?
   Grade level _____

13. Should alcohol and drug education courses be taught exclusively or with other courses?
    a) _____ With other courses
    What courses?_____
    _____
    b) _____ Exclusively
    Why?_____
    _____

14. Do you think that traffic safety education should be combined with alcohol and drug education?
    a) _____ Yes
    Why?_____
    _____
    b) _____ No
    Why not?_____
    _____

15. As it relates to traffic safety, what would be important aspects to cover?
    a) _____ Legal aspects
    b) _____ Pharmacological aspects and health issues
    c) _____ Crime and violence
    d) _____ Driving under the influence and accident potential
    e) _____ Others_____
    _____

16. In your opinion, what needs to happen in order for your current alcohol and drug education program to be more effective?
    _____
    _____
    _____

17. If a proven effective alcohol and drug education program was made available:
    a) under what conditions would the school board and administrators of your district be willing to implement it?_____
    _____
    _____

    b) At what expense?
    1) _____ at no cost to your district
    2) _____ at some cost to your district
    3) _____ at full cost to your district

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